Child and Adolescent Psychology Professionals

Background Questionnaire

Child's name _____ Today's Date _____

Birth date _____ Age _____ Sex: ☐ Male ☐ Female

Home address _____

_____

School _____ Teacher _____ Grade _____

Person(s) filling out this form: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather

☐ Caregiver ☐ Other (please explain) _____

Mother's name _____ Age ____ Occupation _____

Father's name _____ Age ____ Occupation _____

Stepmother's name _____ Age ____ Occupation _____

Stepfather's name _____ Age ____ Occupation _____

Marital status of parents _____ Date of separation or divorce _____

If remarried, date _____ Custody:_____

List all people living in the household(s):

Name	Gender	Relationship to Child	Age

List the name, sex, relationship to child, and age of any brothers, sisters, or significant people living outside the home: _____

_____

_____

Primary language spoken in the home: _____ Other languages: _____

Was the child adopted? ☐ Yes ☐ No What age? _____ Does the child know? ☐ Yes ☐ No

Presenting Problem

Briefly described the child's current difficulties: _____

_____

_____

_____

_____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Have you received evaluation or treatment for the current problem or past problems? ☐ Yes ☐ No

If yes, when and with whom? _____

Any established diagnoses? _____

Social and Behavioral Checklist

Please check any behavior or problem that the child **currently** exhibits.

☐ Making/keeping friends
☐ Refuses to share
☐ Prefers to be alone
☐ Does not get along well with others
☐ Verbally aggressive
☐ Physically Aggressive
☐ Mood swings
☐ Is withdrawn
☐ Is shy or timid
☐ Clings to others
☐ Tires easily
☐ Is more interested in things (objects) than people
☐ Danger to self or others
☐ Breaks objects deliberately
☐ Lies
☐ Steals
☐ Injures self
☐ Runs away

☐ Low self-esteem
☐ Blames others for own troubles
☐ Is argumentative
☐ Does not show feelings
☐ Frequent crying episodes/temper tantrums
☐ Unusual or special fears, habits, or mannerisms
☐ Wets bed
☐ Bites nails
☐ Sucks thumb
☐ Has trouble sleeping
☐ Rocks
☐ Bangs head
☐ Eats poorly
☐ Is stubborn
☐ Has poor bowel control
☐ Is overactive/restless
☐ Is fidgety
☐ Is easily distracted

☐ Is disorganized
☐ Is clumsy
☐ Is unusually talkative
☐ Is forgetful/poor memory
☐ Has blank spells
☐ Daydreams frequently
☐ Worries a lot
☐ Acts without thinking
☐ Doesn't learn from experience
☐ Feels that he/she is bad
☐ Is slow to learn
☐ Engages in stereotyped behavior
☐ Does not understand other people's feelings
☐ Has difficulty following directions
☐ Gives up easily
☐ Complains of aches & pains

☐ Is disobedient
☐ Gets into trouble with the law
☐ Constantly seeks attention
☐ Has periods of confusion or disorientation
☐ Is extremely jealous
☐ Is extremely selfish
☐ Feels hopeless
☐ Is nervous or anxious
☐ Is immature
☐ Is easily frustrated
☐ Has difficulty learning
☐ Is suspicious of others
☐ Requires constant supervision
☐ Difficulty resisting peer pressure
☐ Angers easily
☐ Difficulty accepting criticism
☐ Often sad/unhappy
☐ Talks about wanting to die
☐ Poor attention span
☐ Sets fires
☐ Is afraid of new situations
☐ Eats inedible objects
☐ Is not toilet trained
☐ Uses drugs/alcohol
☐ Shows sexually provocative behavior
☐ Has extreme fear of bathroom or bathing
☐ Has anxiety when separated from parents
☐ Has extreme anxiety about going to school
☐ Has fear at bedtime
☐ Is wary of any physical contact with adults in general
☐ Refuses to sleep alone
☐ Refuses to go to bed
☐ Has loss of bladder control
☐ Is fearful of strangers
☐ (In the case of divorce) Is fearful of visiting a parent or caregiver
☐ Overeats
☐ Is very eager to please others
☐ Refuses to undress for physical education at school
☐ Has compulsion about cleanliness—wanting to wash or feeling dirty all the time
☐ Appears dazed, drugged, or groggy
☐ Other: _____
_____
_____
_____
_____
_____

Language/Speech Checklist

Place a check next to any language or speech problem that the child **currently** exhibits.

☐ Speaks in shorter sentences than expected for age
☐ Does not know names of common objects
☐ Difficulty recalling familiar words
☐ Substitutes vague words for specific words
☐ Responds better to gestures than to words
☐ Does not make appropriate gestures to communicate
☐ Uses gestures instead of words to express ideas
☐ Difficulty making speech understood
☐ Speaks very slowly
☐ Speaks to fast
☐ Is often hoarse
☐ Has unusually loud speech
☐ Has unusually soft speech
☐ Makes sounds but no words
☐ Mixes up the order of events
☐ Seems uninterested in communicating
☐ Prefers to speak to adults only
☐ Prefers to speak to children only
☐ Prefers to speak to family members only
☐ Speaks in a monotone or exaggerated manner

Educational History

Place a check next to any educational problem that the child **currently** exhibits.

☐ Reading
☐ Math
☐ Spelling
☐ Handwriting
☐ Written Expression
☐ Paying attention in class
☐ Sitting still in class
☐ Waiting turn in school
☐ Difficulty taking notes

☐ Remembering things
☐ Forgets homework
☐ Understanding directions
☐ Getting started on work
☐ Asking for help
☐ Turning in homework
☐ Makes careless mistakes
☐ Organization
☐ Finishing a project on time

☐ Getting along with his or her teacher
☐ Respecting others' rights
☐ Dislikes school
☐ Resists going to school
☐ Refuses to do homework
☐ Other: _____

Did your child attend pre-school ☐ Yes ☐ No What ages? _____ How often? _____

At what age did your child begin kindergarten? _____

Is your child in special education? ☐ Yes ☐ No Does your child have an ☐ IEP ☐ 504 plan

If yes, which subjects does your child receive extra support in? _____

_____

Has your child been held back a grade? ☐ Yes ☐ No

If yes, which grade and why? _____

Has your child ever received special tutoring or therapy at school? ☐ Yes ☐ No

If yes, please describe: _____

Does your child (or has your child) participate(d) in tutoring outside of school? ☐ Yes ☐ No

If yes, please describe: _____

Has your child participated in supportive services or interventions outside of school (e.g. occupational therapy, speech, reading or math interventions, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Has your child's school performance declined recently? ☐ Yes ☐ No

If yes, please describe: _____

Has your child missed a lot of school? ☐ Yes ☐ No Reason? _____

Developmental History

Problems during pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

Age of mother when she became pregnant? _____ Was this a first pregnancy? ☐ Yes ☐ No

Number of previous pregnancies? _____

During pregnancy, did the mother smoke? ☐ Yes ☐ No How many cigarettes per day?_____

During pregnancy, did the mother drink alcoholic beverages? ☐ Yes ☐ No

If yes, what did she drink? _____

Approximately how much alcohol did the mother consume each day? _____

During which part of the pregnancy did mother consume alcohol? ☐ 1st ☐ 2nd ☐ 3rd trimester

During pregnancy, did the mother use drugs (including prescription, over-the-counter, & recreational)? ☐ Yes ☐ No What kind? _____

How often? _____

During pregnancy, was the mother exposed to any x-rays or chemicals? ☐ Yes ☐ No

If yes, what kind? _____ How often? _____

During pregnancy, was the mother exposed to any infectious diseases? ☐ Yes ☐ No

If yes, what? _____

Did the mother receive prenatal care? ☐ Yes ☐ No Length of gestational period? _____

Was delivery induced? ☐ Yes ☐ No If yes, how? _____

How long was labor? _____ Were forceps used during delivery? ☐ Yes ☐ No

Was a cesarean section performed? ☐ Yes ☐ No If so, why? _____

Were there any complications associated with delivery? ☐ Yes ☐ No

If yes, please describe: _____

Was your child born premature? ☐ Yes ☐ No

If yes, was special neonatal care required? ☐ Yes ☐ No Please describe: _____

_____

Infancy

Please describe any early complications post-delivery (e.g. infection, jaundice, birth defects, feeding or sleeping problems, colic, specialized care, etc.): _____

_____

_____

As an infant, did your child experience any developmental delays (e.g. delayed milestones), growth problems, sensory sensitivities, medical and/or health problems? If yes, please describe:

_____

_____

First Years

During your child's first years, did he or she show any of the following behaviors?

☐ Difficult to soothe
☐ Poor sleep patterns
☐ Gross motor problems
☐ Did not babble
☐ Did not speak
☐ Excessive fears
☐ Ignored toys
☐ Preferred to play alone
☐ Poor eye contact
☐ Fine motor problems
☐ Excessive restlessness
☐ Excessive number of accidents
☐ Aversive to being held
☐ Did not smile socially
☐ Insensitive to cold or pain
☐ Did not wave good bye
☐ Difficulty separating
☐ Cried excessively
☐ Was indifferent to others

Medical History

Place a check next to any illness or condition that the child has had. When you check an item, also note the approximate age of the child when he or she had the illness or condition.

☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Whooping cough
☐ High Fever
☐ Convulsions
☐ Hay fever
☐ Head injury
☐ Seizures
☐ Broken bones
☐ Hearing problems
☐ Vision problems
☐ Ear infections
☐ Loss of consciousness
☐ Dizziness
☐ Frequent headaches
☐ Difficulty concentrating
☐ Memory problems
☐ Epilepsy
☐ Bone or joint disease
☐ Anemia
☐ Hepatitis
☐ Diabetes
☐ Cancer
☐ High blood pressure
☐ Heart disease
☐ Asthma
☐ Bleeding problems
☐ Eczema or hives
☐ Suicide attempt
☐ HIV/AIDS
☐ Allergies
☐ Other: _____

Is your child being treated for a medical illness? ☐ Yes ☐ No

If yes, for what condition: _____

If your child on any medications at this time? ☐ Yes ☐ No

If yes, please list names of medications and dates started: _____

_____

Name, address, and phone number(s) of prescriber(s):

_____

_____

_____

Does your child have any disabilities? ☐ Yes ☐ No Please describe: _____

_____

Has your child had any serious illnesses? ☐ Yes ☐ No Please describe: _____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No Please describe: _____

_____

Has your child had any operations? ☐ Yes ☐ No Please describe: _____

_____

Has your child had any accidents? ☐ Yes ☐ No Please describe: _____

_____

Are your child's immunizations up to date? ☐ Yes ☐ No Child's height _____ Weight _____

Any family history of:

☐ Alcoholism
☐ Anxiety
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia
☐ Autism/Asperger's
☐ Substance abuse
☐ ADHD
☐ Suicide (attempt or completed)
☐ Learning disability
☐ Behavioral problems
☐ Sleep problems
☐ Eating problems

Other Information

Child's Activities

What are your child's favorite activities? _____

_____

_____

What chores is your child responsible for at home? _____

_____

Describe your child's typical routine (include morning routine, after school, and evening routine; bedtime; activities before or after school; volunteering; employment; religious education; clubs, sports, or social activities; etc.)

_____

_____

_____

_____

What are your child's strengths? _____

What does your child do well? _____

What do you, your child, and the family enjoy doing together? _____

_____

List any current personal, family, or child stressors, changes, losses, or recent adjustments (e.g. move, change of schools, divorce, death of family member, loss of friends, finances, etc.)

_____

_____

Please a check next to each technique that you commonly use when your child behaves inappropriately.

☐ Ignore
☐ Scold/nag
☐ Yell/scream
☐ Spank
☐ Threaten
☐ Reason with your child
☐ Time out
☐ Redirection/distraction
☐ Send child to room
☐ Take away something
☐ Token or other behavioral system
☐ Don't use any technique
☐ Other: _____

Which disciplinary techniques are effective/ineffective? What types of problems? Who is usually involved? _____

_____

Has your child ever been in trouble with the law? ☐ Yes ☐ No Please describe: _____

_____

Has your child (to your knowledge) ever been physically or sexually abused, experience emotional abuse or neglect, and/or witnessed or experienced a life-threatening event? ☐ Yes ☐ No

Please describe: _____

_____

Have you, your family, or your child been involved with Child Protective Services? ☐ Yes ☐ No

Please describe: _____

_____

Treatment Planning

What are your goals for treatment? _____

_____

_____

What are your expectations for behavioral, emotional, or interpersonal change? _____

_____

_____

Do you anticipate any obstacles to behavior change or participation in therapy? _____

_____

Any there any special considerations or limitations that you would like us to be aware of? _____

_____