

Child Background Questionnaire

Date: _____

Please complete this form and bring it with you to your first session. The information you provide is confidential and protected by law.

Child's First Name: _____ Last Name: _____

Child's DOB: _____/_____/_____ Age: _____

Mother's Name: _____

Father's Name: _____

Primary Care Physician: Date of last physical: _____

Name _____ Ph.: _____

Address _____ Fax: _____

1. With whom does the child reside? ___Both Parents ___Mother ___Father
___Joint Custody ___Other: _____

a. List this child's siblings (include half- and step-siblings)

Name	Age	Relationship	Gender	Reside w/ child?	
_____	_____	_____	M / F	Yes	No
_____	_____	_____	M / F	Yes	No
_____	_____	_____	M / F	Yes	No
_____	_____	_____	M / F	Yes	No
_____	_____	_____	M / F	Yes	No

2. Are the parents separated? ___No ___Yes. If yes, when were parents separated? _____

3. Are the parents divorced? ___No ___Yes. If yes, when were parents divorced? _____

4. What concerns do you have regarding your child? _____

5. What school does your child attend? _____ Grade: _____

a. In general, what is your child's attitude toward school?

___Negative ___Neutral ___Positive ___Other: _____

b. Indicate the overall level of your child's grades/academic performance.

___Failing ___Below Average ___Average ___Above Average

c. Has your child been tested for a learning disability or has s/he received special services at school? ___No ___Yes _____

6. a. This child was born at _____ weeks gestation.

b. Mother's age at time of birth? _____

c. Child's birth weight. _____lbs. _____oz.

d. Describe any prenatal concerns, complications during birth, or concerns during the first few months after birth: _____

7. At what age did your child first accomplish the following?

- _____ Sitting without help
- _____ Crawling
- _____ Walking alone, without assistance
- _____ Using single words (mama, dada)
- _____ Putting two or more words together
- _____ Bowel training, day and night
- _____ Bladder training, day and night

8. Describe any current difficulties with:

a. eating: _____

b. weight gain or loss: _____

b. sleeping: _____

c. toileting: _____

d. energy levels: _____

e. attention levels: _____

f. other: _____

g. other: _____

9. Describe any past or current medical problems, including hospitalizations and surgeries.

10. Please list any medications your child is currently taking.

Medication Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

11. List any allergies your child has. _____

12. Does anyone in the child's family have significant medical or mental health concerns (e.g., mother, father, siblings, grandparents, aunts/uncles)? No Yes

13. List any extracurricular activities that your child participates in. _____

14. Describe your child's social relationships with same-aged peers. _____

15. Please describe any additional important information you would like your clinician to know.
