THE FAMILY CENTER
CHILD/FAMILY HISTORY QUESTIONNAIRE

Date questionnaire completed ___________________

IDENTIFYING INFORMATION

Child's Name __________________________________ Date of Birth ______________ Sex _________

School ____ Current Grade ___________________

Parents/Legal Guardians ____

Address ____ Home Phone ____________________

____ Cell Phone ____________________

Primary language spoken in home ________________Email Address__________________________

REFERRAL INFORMATION

Reason for referral (What is the main problem for which you are seeking help?) _______________

____

____

____

How often does the problem behavior occur? (5x/day, 2x/week, etc.) ________________________

How long has your child had this problem? ____

____

How is this problem affecting your child at home? In school? In peer relationships? __________

____

____

____

Has your child been seen previously for psychological or psychiatric consultation? _____________

If yes, name of professional ____

Dates of service ____

Was an evaluation completed? ____________ What type of evaluation? ________________

(If yes, please attach a copy of the evaluation to this questionnaire)

Will you grant permission for us to consult with this professional? _____________________

(If yes, please sign attached Consent Form)

BACKGROUND INFORMATION

Medical

Is child adopted? ______ Date of adoption ________________ Age of child at adoption ___________

Is the child a twin (or other multiple)? ____________ Identical? __________

How long was pregnancy? __________ months. Any complications? ______ If so, describe _______

____

How long was labor?________ hours. Any complications? ________ If so, describe ______________

____

Was delivery through natural childbirth?_________________ C-section? ________________________

Was delivery in the hospital?_______ Home?________ Other? (Please specify) _________________

Were there any complications during delivery? ____ If so, describe ____________________________

____

Child's birth weight _________ Height _______ Any complications following delivery? ___________

If so, describe ____

How long did mother and child remain hospitalized after delivery? ____________________________

Please indicate with an "x" any illness or disease which your child has had, and indicate date:

- Adverse drug reactions
- Allergies (specify: _________________)
- Asthma
- Frequent/recurring…
    - Colds
    - Gastrointestinal problems
    - Headaches
    - High fevers
    - Influenza
    - Migraine headaches
    - Pneumonia
    - Seizures
    - Sinusitis
    - Sore throats
    - Strep throat
- Broken bones (specify:_____________)
- Dizziness/ Fainting
- High/Low blood pressure
- Insertion/removal of tubes
- Chickenpox
- Measles
- Mumps
- Substance abuse
- Surgeries, such as:
    - Appendectomy
    - Heart surgery
    - Tonsillectomy
    - Other (specify: _____________)
- Arthritis
- Cancer
- Cerebral palsy
- Diabetes
- Diphtheria
- Encephalitis
- Exposure to lead
- Meningitis
- Polio
- Tuberculosis

Has your child ever hit his/her head? _______________

Has your child ever been hospitalized overnight? ________________

Condition for which hospitalized	Date	Length of hospitalization

Name of pediatrician ____

Is your child currently on any medications or dietary supplements? ______________

Medication and dosage	Diagnosis	Prescribing physician	Date of initial prescription

Does your child have any vision problems? _______ Does your child wear glasses? ___________

Contact lenses? ___________ Glasses/lenses prescribed, but child does not wear ____________

Date of last vision exam _________________ Results: Right eye _____/20 Left eye _____/20

Does your child have any hearing problems? ____________ Does your child require hearing aids or other devices to amplify sounds? __________ Specify: ______________________________

Average number of hours of sleep per night ________ Frequent waking or nightmares? _______

Do you have concerns about your child's weight? _________

What percentage of food is home cooked? _________

Describe any unusual eating habits (picky eater, eating nonedible items, etc.) ______________

____

Please list any known food/drug allergies: ____________________________________

Developmental

Early childhood

Please indicate with an "x" in each column to indicate when your child demonstrated each developmental milestone:

Child walked:

- ☐ < 12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ > 36 months
- ☐ has never walked

Child spoke words:

- ☐ < 12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ > 36 months
- ☐ has never spoken words

Child spoke sentences:

- ☐ < 12 months
- ☐ 12-24 months
- ☐ 24-36 months
- ☐ > 36 months
- ☐ has never spoken sentences

Child first trained for urination:

- ☐ < 12 months
- ☐ 12-36 months
- ☐ 3-5 years
- ☐ > 5 years
- ☐ not yet trained

Child first trained for bowels:

- ☐ < 12 months
- ☐ 12-36 months
- ☐ 3-5 years
- ☐ > 5 years
- ☐ not yet trained

Since initial toilet training:

- ☐ Frequent wetting during day
- ☐ Frequent wetting during night

Since initial toilet training:

- ☐ Frequent soiling during day
- ☐ Frequent soiling during night

Puberty

Please indicate with an "x" to indicate when your child first demonstrated:

Onset of puberty (breast development, menstruation, pubic hair, facial hair):

- ◻ < 10 years
- ◻ 10-12 years
- ◻ 12-14 years
- ◻ 14-16 years
- ◻ > 16 years
- ◻ not yet developed

Educational

List all schools your child has attended, beginning with the most recent:

School	Grade	Date of entry	Date of Withdrawal

(If this is an educational concern, please attach copies of report cards)

Has your child ever repeated a grade? ____________ Reason ______________________________

Has your child ever had problems in school? ____________ Describe ______________________

____

____

Please indicate with an "x" where you feel your child is performing academically:

Subject	**Below grade level**	**On grade level**	**Above grade level**
Language Arts/Reading			
Mathematics			
Writing			

Does your child enjoy attending school? __________ If no, please explain ___________________

____

Has your child ever been referred for educational interventions, such as additional academic assistance, behavioral management plans, etc? _________If yes, please describe _______________

____

____

Is your child currently on a 504 Plan? ____________ Diagnosis ____________________________

504 Plan interventions ____

____

Is your child currently in Special Education? _________ Date of most recent IEP_______________

Educational Disability ___________________ Services receiving ___________________________

____

Do you feel the interventions (informal/504/Special Education) are effective? ________________

If no, please explain ____

____

Family/Home Environment

Please list all those living in child's home (including child being referred)

Name	Relationship	Date of Birth	Occupation/School & Grade

Please list other persons closely involved with child but not living in child's home (e.g., older siblings, grandparents, sitters, teachers, religious leaders, etc.)

Name	Place of Residence	Frequency of visits

If child is not currently living with both biological parents,

- Is either parent deceased? ______ If so, please specify________________________________
- Were biological parents married? __________
- Are biological parents divorced/separated? ________ If so, when? ______________________
- Which parent has custody? _____________ How often does the non-custodial parent visit?

  ____

How long have you lived at the current address? _____________________________________

How often have you changed residences since the birth of this child? ___________________

Does the child share a bedroom? ___________ With whom? ___________________________

Does your child have any difficulty with siblings? _________ If yes, please explain ______________

____

Was the child ever placed or boarded away from the family? _____If yes, where and with whom?

____

Reason for placement ____

Has your child ever had difficulty or contact with legal authorities (Police, Juvenile Justice)? _______ If yes, please describe circumstances ____

____

Please describe any religious or cultural beliefs you would like incorporated into your child's treatment. ____

Family History

Please indicate if any of the following issues are currently being experienced within the immediate family (parents, siblings):

- ☐ Marital difficulties
- ☐ Divorce/separation of parents
- ☐ Serious illness of parent, child, sibling (specify: ________________)
- ☐ Birth of new child
- ☐ Death in family
- ☐ Recent move
- ☐ Financial problems
- ☐ Single parent
- ☐ Job loss
- ☐ Other: ___________________________ ___________________________

Please indicate which of the following concerns have been experienced in the immediate and/or extended family (parents, siblings, aunts, uncles, cousins, grandparents):

Concern	Relationship to Child *(specify maternal or paternal and relationship)*
☐ Autism Spectrum Disorders	______________________
☐ Learning Disabilities	______________________
☐ Mental Retardation	______________________
☐ Birth Defects	______________________
☐ Cancer	______________________
☐ Diabetes	______________________
☐ Attention Deficit Hyperactivity Disorder (ADHD)	______________________
☐ Alcoholism	______________________
☐ Drug addiction	______________________
☐ Depression	______________________
☐ Bipolar Disorder	______________________
☐ Suicide (threats/attempts/completed)	______________________
☐ Anxiety	______________________
☐ Phobias (specify ______________)	______________________
☐ Psychiatric Hospitalizations	______________________
☐ High Blood Pressure	______________________
☐ High Cholesterol	______________________
☐ Heart Disease	______________________

Academic/Behavioral Checklist

Please indicate with an “x” if your child is currently exhibiting difficulty with any of the following (for the most serious concerns, please circle the item):

ACADEMIC

Reading – Basic skills
- ☐ Difficulty recognizing letters
- ☐ Difficulty reciting the alphabet
- ☐ Difficulty reading aloud – (loses place or skips words)
- ☐ Dislikes reading/reluctant to read
- ☐ Reads slowly

Reading - Comprehension
- ☐ Difficulty understanding the meaning of words
- ☐ Difficulty understanding the meaning of passages
- ☐ Difficulty identifying main idea
- ☐ Difficulty drawing conclusions
- ☐ Difficulty following written directions
- ☐ Difficulty understanding idioms or figurative language

Math Calculation
- ☐ Difficulty identifying numerals
- ☐ Difficulty counting by rote
- ☐ Difficulty understanding basic arithmetic facts
- ☐ Difficulty completing problems involving basic calculation
- ☐ Difficulty completing problems involving fractions or decimals
- ☐ Difficulty completing problems involving geometric shapes
- ☐ Difficulty completing problems with more than one step

Math Reasoning
- ☐ Difficulty understanding concepts related to size, sequence, or quantity
- ☐ Difficulty identifying and using appropriate problem-solving strategies
- ☐ Difficulty solving word problems
- ☐ Difficulty completing problems involving estimation or prediction
- ☐ Difficulty understanding charts, tables, and graphs
- ☐ Difficulty generalizing math skills to other types of problems or tasks
- ☐ Difficulty understanding abstract mathematical concepts

Written Expression
- ☐ Difficulty writing information dictated by others
- ☐ Difficulty with basic mechanics of writing
- ☐ Confuses the order of words in sentences
- ☐ Writes in incomplete sentences
- ☐ Uses simplistic language when writing
- ☐ Difficulty expressing ideas in writing
- ☐ Dislikes/avoids written tasks
- ☐ Poor handwriting (difficulty with letter formation, poor spacing between letters and words)
- ☐ Difficulty copying from blackboard

Oral Expression
- ☐ Confuses or leaves out speech sounds
- ☐ Dysfluency (unusual pauses or repetitions, frequent rephrasing, poor verbal organization)
- ☐ Grammatical problems (incorrect use of plurals, verb tense forms, pronouns, etc.)
- ☐ Limited vocabulary
- ☐ Word retrieval problems
- ☐ Problems with social language (initiating conversations, expressing thoughts and feelings, asking questions, etc.)
- ☐ Does not speak in class to teachers/students

Listening Comprehension
- ☐ Difficulty following oral directions
- ☐ Frequently asks for repetition of oral instructions
- ☐ Misunderstands spoken word
- ☐ Easily distracted by noises or other sounds
- ☐ Exhibits short attention span during auditory tasks
- ☐ Confuses similar words
- ☐ Difficulty understanding sentences that are long or complex
- ☐ Cannot remember information presented verbally
- ☐ Cannot repeat information that was just spoken
- ☐ Appears disinterested in audio information (tapes, recordings, etc.)
- ☐ Demonstrates disruptive or off-task behaviors when required to listen
- ☐ Difficulty responding to questions within expected time limits

SOCIAL/EMOTIONAL/BEHAVIORAL

Social
- ☐ Misinterprets facial expressions or body language
- ☐ Overreacts to perceived insults
- ☐ Does not understand teasing, sarcasm, jokes

Social (cont'd)

- ☐ Has few or no friends
- ☐ Displays attention-getting behaviors, acts like "class clown"
- ☐ Misinterprets tone of voice
- ☐ Isolated from others – few group or social interactions
- ☐ Withdrawn – does not make eye contact, seems introverted, does not participate in discussions

Emotional

- ☐ Excessive crying
- ☐ Overreacts to normal situations with excessive anger, fear, sadness, etc.)
- ☐ Excessively afraid
- ☐ Excessively happy
- ☐ Gives up when challenged
- ☐ Appears depressed
- ☐ Appears excessively angry
- ☐ Does not talk

Behavioral

- ☐ Excessively out of seat
- ☐ Refuses to comply with requests
- ☐ Frequently off-task
- ☐ Withdrawn
- ☐ Interrupts others when speaking
- ☐ Uses foul language
- ☐ Frequently fights with peers
- ☐ Engages in risky behaviors
- ☐ Associates with children that have been in trouble
- ☐ Difficulty focusing
- ☐ Poorly organized
- ☐ Experiences difficulty starting tasks
- ☐ Acts before thinking
- ☐ Can't sit still
- ☐ Experiences difficulty planning

ADDITIONAL COMMENTS

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____

____

____

____

____

Person completing this form ____

Relationship to client ____

Referred by ____

Thank you for taking the time to complete this questionnaire thoroughly!

The Family Center