Ptarmigan Connections
3505 E Meridian Park Lp Ste 200
Wasilla, AK 99654
907-357-4400 (office)
907-357-4410 (fax)
ptarmiganconnections.com

BACKGROUND QUESTIONNAIRE

Confidential

The following is a detailed questionnaire on your child's development, medical history, and current functioning at home and at school. This information will be integrated with the verbal interview to provide a better picture of your child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

Child's Name:_____ Today's Date:_____

Birthdate: _____ Age:_____ Grade: _____ Name of School:_____

Ethnic background:_____ Language(s) spoken in the home:_____

This referral was initiated by:_____

What is the main concern leading to this referral? _____

Person filling out this form: ☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other_____

MEDICAL HISTORY

Current Medical diagnoses:_____

Current Mental Health diagnoses:_____

Vision problems ☐No ☐Yes:_____ Date of last vision exam:_____

Hearing problems ☐No ☐Yes:_____ Date of last hearing exam:_____

Dental problems ☐No ☐Yes:_____ Date of last dental exam:_____

Child's Primary Care Provider_____Phone:_____

Child's other Provider(s):_____

_____

Current Medications	Dosage	Purpose

Past Medications	Purpose	Reason for discontinuation of medication

Medication Allergies	Reaction

Other Allergies:

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date of illness (if you prefer, you can indicate child's age at illness).

Illness or condition ***Date(s) or age(s) and details***

☐ Childhood illnesses _____

Circle all that apply: Measles, Mumps, Chicken pox, Whooping cough, Diptheria, Scarlet fever, Tuberculosis, Mono, Lyme

☐ Cardiovascular _____

Circle all that apply: Anemia, Jaundice, High blood pressure, Heart disease, Bleeding problems

☐ Pulmonary _____

Circle all that apply: Asthma, Chronic bronchitis, Pneumonia, Cystic fibrosis, Tuberculosis

☐ Gastrointestinal _____

Circle all that apply: Recurrent stomach aches, Reflux, Heart burn, Diarrhea, Constipation, Food intolerances, Poisoning

☐ Genitourinary _____

Circle all that apply: Urinary tract infections, Bed-wetting, kidney disease, endometriosis, polycystic ovaries, sexually active

☐ Musculoskeletal _____

Circle all that apply: Broken bones, Chronic pain, Arthritis, Osgood-Schlatter, Scoliosis

☐ Endocrine _____

Circle all that apply: Recurrent fevers, Diabetes, Hypothyroid, Cancer

☐ Neurologic/Genetic _____

Circle all that apply: Meningitis, Encephalitis, Seizures, Fainting, Injuries to head, Loss of consciousness, Severe headaches

☐ Allergy/Dermatology _____

Circle all that apply: Trees, Mold, Grass, Pets, Dust, Foods, Chemicals, Dyes, Hives, Eczema, Rash

☐ Ear/Nose/Throat _____

Circle all that apply: Ear infections, Nose bleeds, Recurrent strep, Glasses/contacts, Hearing aid, TMJ

☐ Other conditions _____

☐ Surgeries _____

☐ Hospitalizations _____

☐ Lab work/imaging _____

SYMPTOM CHECKLIST

Place a check mark next to behaviors that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

Sleeping

☐ # of hours of sleep_____
☐ Bed time routine
☐ Restless/excessive movements in bed
☐ Trouble falling asleep
☐ Trouble staying asleep
☐ Nightmares
☐ Snoring
☐ Day time fatigue
☐ Napping

Social Development

☐ Prefers to be alone
☐ Excessively shy or timid
☐ Difficulty making friends
☐ Teased by others
☐ Bullies others
☐ Difficulty seeing other's point of view
☐ Doesn't empathize
☐ Overly trusting of others
☐ Doesn't appreciate humor

Eating

- ☐ Picky eater
- ☐ Change in appetite
- ☐ Eats excessively
- ☐ Lacks appetite
- ☐ Special diet_____

Motor Skills

- ☐ Uncoordinated with small movements
- ☐ Uncoordinated with large movements

Mood

- ☐ Seems depressed/Sad
- ☐ Cries frequently
- ☐ Loss of interest in things
- ☐ No joy/ happiness
- ☐ Feelings of guilt
- ☐ Feelings of worthlessness
- ☐ Low motivation
- ☐ Difficulty making decisions
- ☐ Easily bored
- ☐ Irritable, angry, or resentful
- ☐ Talks about death
- ☐ Threats of suicide
- ☐ Easily distractible
- ☐ Keyed up/ on edge
- ☐ Overly impressed with self
- ☐ Thoughts on fast-forward
- ☐ ↑Activity w/ ↓ need for sleep

Anxiety

- ☐ Excessively worried and anxious
- ☐ Muscle tension
- ☐ Ruminating (repetitive & negative) thoughts
- ☐ Checking and rechecking things
- ☐ Obsessive counting
- ☐ Panic
- ☐ Hypervigilance
- ☐ Flash backs/ relive trauma
- ☐ Easily startled
- ☐ Phobias (describe):

_____

Behavior

- ☐ Fidgety
- ☐ Can't stay seated
- ☐ Always on the go
- ☐ Climbs excessively
- ☐ Disrupts other students
- ☐ Difficulty waiting turn
- ☐ Argues with adults
- ☐ Loses things
- ☐ Stubborn
- ☐ Frequent tantrums
- ☐ Strikes out at others
- ☐ Throws or destroys things
- ☐ Cruelty to animals
- ☐ Uses weapons in fights
- ☐ Fire setting
- ☐ Lying
- ☐ Stealing
- ☐ Runs away
- ☐ Needs a lot of supervision
- ☐ Impulsive (does things without thinking)
- ☐ Poor sense of danger
- ☐ Skips school
- ☐ Reckless
- ☐ Self-destructive
- ☐ Skin picking, hair pulling, nail biting
- ☐ Repetitive behaviors
- ☐ Too little energy
- ☐ Drug use
- ☐ Alcohol use
- ☐ Sexually active
- ☐ Dangerous to self or others (describe):

_____

- ☐ Purposely harms or injures self (describe):

_____

- ☐ Talks about killing self (describe):

_____

- ☐ Unusual habits or mannerism (describe):

_____

Cognitive

- ☐ Slow thinking
- ☐ Slow learner
- ☐ Unable follow directions
- ☐ Forgetful
- ☐ Easily distracted
- ☐ Makes careless mistakes
- ☐ Doesn't seem to listen
- ☐ Difficulty organizing tasks
- ☐ Doesn't foresee consequences of actions
- ☐ Difficulty with math/handling money
- ☐ Poor understanding of time
- ☐ Visual hallucinations
- ☐ Auditory hallucinations
- ☐ Excessive daydreaming
- ☐ Thoughts on fast-forward

Speech

- ☐ Talks like a younger child
- ☐ Difficulty expressing self
- ☐ Uses obscene language
- ☐ Talks excessively/loud/fast
- ☐ Interrupts
- ☐ Stutters
- ☐ Poor articulation
- ☐ Ungrammatical speech

Other Problems

- ☐ Bladder control problems (not during seizure)
- ☐ Poor bowel control (soils self)
- ☐ Motor/vocal tics
- ☐ Overreacts to noises
- ☐ Overreacts to touch
- ☐ Excessive daydreaming and fantasy life
- ☐ Problems with taste or smell

Other Problems

OTHER INFORMATION

What are your child's chores?_____

On the average, what percentage of the time does your child comply with requests or commands?

What have you found to be the most effective ways of helping your child?

Has your child ever been in trouble with the law? ☐ No ☐ Yes

If yes, please describe briefly: _____

What are your child's assets or strengths?

List any assessments that your child has had:

	Date of testing	*Name of Examiner*
Psychiatric	_____	_____
Psychological	_____	_____
Neuropsych Evaluation	_____	_____
Educational	_____	_____
Speech pathology	_____	_____
Other	_____	_____

List any treatment (psychological/psychiatric) that your child has had (e.g., individual therapy, group therapy, family therapy, speech therapy, occupational therapy, physical therapy, applied behavioral analysis (ABA), inpatient hospitalization, residential treatment etc.):

Type of treatment ***Dates*** ***Name of provider***

_____

_____

_____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Place a check next to any illness or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had. Please note the family member's relationship to the child

Condition	***Relationship to child***	***Condition***	***Relationship to child***
☐ Seizures or epilepsy	_____	☐ Heart condition	_____
☐ Attention deficit	_____	☐ High blood pressure	_____
☐ Hyperactivity	_____	☐ High cholesterol	_____
☐ Learning disabilities	_____	☐ Overweight/obese	_____
☐ Intellectual disabilities	_____	☐ Diabetes	_____
☐ Tics or Tourette's	_____	☐ Cancer	_____
☐ Alcohol abuse	_____	☐ Neurological illness	_____
☐ Drug abuse	_____	☐ Dental problems	_____
☐ Depression	_____	☐ Stomach issues	_____
☐ Anxiety	_____	☐ Headaches/migraines	_____
☐ Bipolar	_____	☐ Sexually transmitted illness	_____
☐ Schizophrenia	_____	☐ Lyme disease	_____
☐ Suicide attempt	_____	☐ Allergies	_____
☐ Physical abuse	_____	☐ Antisocial (assaults, theft, etc.)	_____
☐ Sexual abuse	_____	☐ Other	_____
☐ Childhood behav. problems	_____	☐ Other	_____

SOCIAL HISTORY

Mother's Name: _____ Age:_____ Highest Grade Completed:_____

Number of Years of Education:_____ Degree/Diploma (if applicable):_____

Occupation:_____

Father's Name:_____ Age:_____ Highest Grade Completed:_____

Number of Years of Education:_____ Degree/Diploma (if applicable):_____

Occupation:_____

Marital status of biological parents: _____

If parents are separated or divorced:

How old was this child when the separation occurred?_____

Who has legal custody of the child? (check one) ☐Mother ☐Father ☐Joint/Both ☐Other:_____

Stepparent's Name:_____ Age:_____ Occupation:_____

If this child is not living with either biological parent, who are they living with:

☐Adoptive parents ☐Foster parents ☐Other family members ☐Group home ☐Other:_____

Reason:_____

How old was this child when the placement occurred?_____

Other out-of-home placements:

Name(s) of legal guardian(s):_____

Marital status of legal guardian(s): _____

Occupation of legal guardian (s):_____

List all people currently living in your child's household:

Name *Relationship to child* *Age*

_____

_____

_____

_____

_____

If any siblings are living outside the home, list their names and ages:

Name *Relationship to child* *Age*

_____

_____

_____

Pets: _____

What are your child's favorite activities? _____

Does your child engage socially with their peers?_____

What is your child's main social support outside of the home?

_____

What is your child's preferred religion? _____

What is the family's preferred religion? _____

DEVELOPMENTAL HISTORY

During pregnancy, did the mother of this child: take any medication? ☐Yes ☐No

If yes, what kind?_____

Smoke? ☐Yes ☐No If yes, how many cigarettes each day?_____

Drink alcoholic beverages? ☐Yes ☐No

If yes, what kind?_____

Approximately how much alcohol was consumed each day?_____

Use of non-prescription drugs? ☐Yes ☐No

If yes, what kind?_____

How often were drugs used?_____

Check any of the following complications that were present during your pregnancy with this child:

☐High blood pressure	☐Excessive vomiting	☐Convulsions/fainting
☐Bleeding	☐Toxemia	☐Diabetes
☐Anemia	☐Infections	☐Accident

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____

Check any of the following that apply:

☐ Labor induced ☐Forceps ☐Breech ☐Cesarean ☐Fetal distress

If yes on any of the above, for what reasons?

_____

Birth weight of child: _____ Apgars:_____/_____

Check any that apply following birth:

☐Jaundice ☐Breathing problems ☐Incubator ☐Birth defect

☐Feeding problems ☐Sleeping problems ☐Growth/developmental problems

If yes to any of the above, please describe:

Were any of the following present (to a significant degree) during infancy or the first few years of life?

☐Unusually quiet or inactive	☐Excessive accidents compared with others
☐Did not like to be held or cuddled	☐Delayed speech
☐Not alert	☐Delayed walking
☐Difficult to soothe	☐Problems toilet training
☐Colic	☐Difficulty gaining weight or growing
☐Excessive restlessness	☐Diminished sleep
☐Head banging	☐Constantly into everything

Menstruation started approximately: _____

Check any of the following that apply during or preceding menstruation:

☐Mood changes	☐Cramping	☐Nausea
☐Bloating	☐Headaches	☐Anxiety

Adverse Childhood Experiences:

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's provider in assessing their health and determining guidance. Please read the statements below. Check off the statements that apply to your child.

Section 1. At any point since your child was born…

- ☐ Your child's parents or guardians were separated or divorced
- ☐ Your child lived with a household member who served time in jail or prison
- ☐ Your child lived with a household member who was depressed, mentally ill or attempted suicide
- ☐ Your child saw or heard household members hurt or threaten to hurt each other
- ☐ A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- ☐ Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- ☐ More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- ☐ Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- ☐ Your child lived with someone who had a problem with drinking or using drugs
- ☐ Your child often felt unsupported, unloved and/or unprotected

Section 2. At any point since your child was born…

- ☐ Your child was in foster care
- ☐ Your child experienced harassment or bullying at school
- ☐ Your child lived with a parent or guardian who died
- ☐ Your child lived away from her/his primary caregiver
- ☐ Your child had a serious medical procedure or life threatening illness
- ☐ Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- ☐ Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

Have there been any recent stressors not mentioned above that may be contributing to your child's difficulties (e.g., illness, deaths, operations, accidents, separation/divorce of parents, remarriage, parent to change jobs, change schools, family moved, family financial problems, sexual traumas, other losses)?

EDUCATION HISTORY

Schools Attended *Grade(s)*

_____

_____

_____

_____

Does your child have a modified learning program? ☐Yes ☐No

Is there an individual education plan (IEP)? ☐Yes ☐No

Is your child classified as?

☐Learning disabled

☐Speech/Language disordered

☐Severely emotionally disturbed

☐Other Health Impaired (for what condition_____)

Please indicate average reports for your child: ☐As & Bs (3s &4s) ☐Cs & Ds (1s & 2s) ☐ Failing

Difficult subjects:_____

Favorable subjects:_____

Are you satisfied with your child's current learning program? ☐Yes ☐No If not, please explain:

Has your child been held back a grade? ☐Yes – indicate grade:_____ ☐No

Is your child currently receiving any of the following at school:

☐Special education classes ☐Learning assistance ☐ Tutoring

If yes, please describe

Has your child been suspended or expelled from school? ☐Yes ☐No

If yes, please describe:

Briefly describe classroom or school problems if applicable:

Thank you for filling out this questionnaire