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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: _____ Also known as: _____ Today's Date: _____

Birthdate: _____ Age: _____ Grade: _____

Name of School: _____ Primary Teacher Name: _____

Ethnic background: _____ Tribe: _____ 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 Foster parent
 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, Diphtheria, 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
- Tobacco or Cannabis 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 and fantasy life

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
- 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:

| | <i>Date of testing</i> | <i>Name of Examiner</i> |
|-----------------------|------------------------|-------------------------|
| 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.):

| <i>Type of treatment</i> | <i>Dates</i> | <i>Name of provider</i> |
|--------------------------|--------------|-------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

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

SOCIAL HISTORY

Custodial Parent: _____ Age: _____ Highest Grade Completed: _____

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

Occupation: _____

Custodial Parent: _____ Age: _____ Highest Grade Completed: _____

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

Occupation: _____

Marital status of 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: _____

Bio Mom Name: _____ Age: _____ Occupation: _____

Bio Dad Name: _____ Age: _____ Occupation: _____

Bio Siblings? Yes No If YES, how many? _____

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:

OCS Caseworker: _____ Phone #: _____ Email: _____

Guardian Ad Litem: _____ Phone#: _____ Email: _____

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

Marital status of custodial guardian(s): _____

Occupation of custodial guardian (s): _____

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

| <i>Name</i> | <i>Relationship to child</i> | <i>Age</i> |
|-------------|------------------------------|------------|
| | | |
| | | |
| | | |

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

| <i>Name</i> | <i>Relationship to child</i> | <i>Age</i> |
|-------------|------------------------------|------------|
| | | |
| | | |
| | | |

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Convulsions/fainting |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Infections | <input type="checkbox"/> 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:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Incubator | <input type="checkbox"/> Birth defect |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> 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?

- | | |
|---|---|
| <input type="checkbox"/> Unusually quiet or inactive | <input type="checkbox"/> Excessive accidents compared with others |
| <input type="checkbox"/> Did not like to be held or cuddled | <input type="checkbox"/> Delayed speech |
| <input type="checkbox"/> Not alert | <input type="checkbox"/> Delayed walking |
| <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Problems toilet training |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Difficulty gaining weight or growing |
| <input type="checkbox"/> Excessive restlessness | <input type="checkbox"/> Diminished sleep |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Constantly into everything |

Patient menstruation started approximately (if applicable): _____

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

- | | | |
|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Mood changes | <input type="checkbox"/> Cramping | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Headaches | <input type="checkbox"/> 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