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An Association of Independent Practitioners

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HISTORY QUESTIONNAIRE

Name of Child: _____ Date of Birth: _____

Name of Person Completing Form: _____

Relationship to Child: _____

Today's Date: _____

Family Physician/Pediatrician: _____

Address: _____

_____

Telephone: _____

Please list previous mental health treatment received, if any: _____

_____

Who referred your child to this agency? _____

I. Family History

Mother's Name: _____ Age: _____

Highest Level of Education Completed: _____ Occupation: _____

Place of Employment: _____

Father's Name: _____ Age: _____

Highest Level of Education Completed: _____ Occupation: _____

Place of Employment: _____

Step-parent's or Guardian's Name (if Applicable): _____ Age: _____

Highest Level of Education Completed: _____ Occupation: _____

Place of Employment: _____

Parents are:

Married: _____	Date: _____
Separated: _____	Date: _____
Divorced: _____	Date: _____
Unmarried: _____	Date: _____
Widowed: _____	Date: _____

If parents are divorced, who has legal custody? _____

If parents are separated or divorced, please describe physical custody and visitation arrangements: _____

Is this a foster child? Yes ____ No ____
Is this child adopted? Yes ____ No ____

If a foster child or adopted, how long has this child been living with you? _____
If a foster child or adopted, has this been discussed with the child? Yes ____ No ____

How long has the child been living in the current home or apartment? _____

How many times has your child moved in his/her lifetime? _____

Who provides care for your child while you are at work (if applicable)? _____

Is there anyone else living in your home? _____

Please list anyone in the immediate or extended family with a history of learning problems in school:

Person (parent, grandparent, brother, aunt, etc.)	**Type of Problem** (language, attention, reading, math, etc.)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list anyone in the immediate or extended family with a history of behavioral or emotional problems:

Person (parent, grandparent, brother, aunt, etc.)	**Type of Problem** (trouble with the law, depression, drug abuse, alcoholism, anxiety, psychotic, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

Please list anyone in the immediate or extended family with a history of medical problems:

Person (parent, grandparent, etc.)	**Type of Problem**
_____	_____
_____	_____
_____	_____

Please list any ethnic/religious/cultural issues you would like us to be aware of _____
_____
_____

Please list any previous mental health treatment received if any: _____
_____
_____

II. School History

Current Grade Placement: _____

School Name: _____

Address: _____
Street

City State Zip Code

Contact Person (If applicable): _____

Did/Does your child attend preschool? Yes ____ No ____

If yes, give ages of attendance: _____
Preschool Name: _____
Were there any problems? If yes, describe: _____
_____

Age at kindergarten entrance: _____

Were there any problems? If yes, describe: _____
_____

Has your child ever repeated a grade? Yes ____ No ____ If yes, which grade(s)? _____

Has your child ever been evaluated or tested before? If yes, when and by whom? _____
_____

If not, has an evaluation been requested at school? Yes ____ No ____
Does your child have an IEP or a 504 Plan? Yes ____ No ____

How many schools has she/he attended? _____

Has your child received any of the following services?:

	Yes	No	Ages or Grades
Speech/Language Therapy	____	____	_____
Physical Therapy	____	____	_____
Occupational Therapy	____	____	_____
Special Education	____	____	_____
Private Tutoring	____	____	_____
Other (please describe)	____	____	_____

III. Birth and Development History

	Yes	No
Was prenatal care received?	____	____
Were cigarettes consumed during pregnancy?	____	____
If yes, how many packs a day? ____		
Was alcohol consumed during pregnancy?	____	____
If yes, how many days per week on average? ____		

	Yes	No
Were any drugs not prescribed by a doctor during pregnancy? (such as marijuana, cocaine, speed, heroine, others)?	____	____

If yes, please list: 1)
2)
3)

Was medication used during pregnancy?	____	____

If yes, please list: 1)
2)
3)

Did pregnancy last a full 9 months?	____	____

If no, please list the length of the pregnancy in weeks: _____

Was the pregnancy complicated by:

____ Excessive weight gain?
____ Weight loss? (not relevant if placed on reducing diet or water pills)
____ Excessive nausea and/or vomiting lasting more than three months?
____ Spotting or light bleeding?
____ Heavy bleeding requiring bed rest or special treatment?
____ Infection (like kidney infection requiring medical care)?
____ High blood pressure and/or excessive fluid in your body?
____ Convulsions (no epilepsy present before pregnancy)?
____ Accidents requiring medical care?

What type of labor (e.g. fast, long, easy, hard)? _____

How long did labor last in hours? _____

Were there any problems with the delivery? Yes ____ No ____
If yes, please describe the problems (e.g. emergency Caesarean section, slow heart rate, fever, cord around neck, etc.) _____
_____

How much did your baby weigh at birth? _____

Did your baby require special care shortly after birth? Yes ____ No ____
If yes, please describe the type(s) of care (e.g. blood transfusions, Oxygen, incubator, medications, etc.) _____

Did the baby have to stay in the hospital after the mother went home? Yes ____ No ____

Describe your baby's temperament as an infant (e.g. crying day and night, never satisfied, too

quiet, still when held, seemed to push you away, cuddly, cheerful, pleasant): _____
_____

Was your baby breast fed? Yes ____ No ____
If yes, how long? _____
Any problems? If yes, list: 1)
2)
3)

Bottle fed? Yes ____ No ____
If yes, how long? _____
Any problems? If yes, list: 1)
2)
3)

Was there difficulty in finding the right formula? Yes ____ No ____
Was the baby usually held when feeding? Yes ____ No ____
Were there any sleeping problems during infancy? Yes ____ No ____

How did your child's achievement of milestones compare to the following ranges?

Sit up: Early ____ On-time ____ Late ____ [Comments:]
(Range: 6-8 months)
Crawl: Early ____ On-time ____ Late ____
(Range: 7-10 months)
Walk: Early ____ On-time ____ Late ____
(Range: 10-16 months)
Use words which meant something:
Early ____ On-time ____ Late ____
(Range: 12-24 months)
Use short sentences:
Early ____ On-time ____ Late ____
(Range: 24-36 months)

Compared to other children, do you feel that your child has been slower in learning…

	Yes	No
To Talk?	____	____
To understand?	____	____
To build with blocks, play with puzzles, draw pictures?	____	____
Gross motor skills (walking, hopping, riding bicycle, etc.)?	____	____
Fine motor skills (fastening buttons, zippers, drawing, etc.)?	____	____
Early school-related skills (naming colors, saying alphabet)?	____	____
To sit still for TV or stories?	____	____
To play or socialize with other children?	____	____
Has this child had difficulty separating?	____	____

If yes, at what age? _____

Is your child toilet trained? ____ ____
If yes, at what age? _____

	Yes	No
Does your child have toileting accidents during the day?	____	____
If yes, how often? _____		
Does your child have toileting accidents at night?	____	____
If yes, how often? _____		
Has your child had any sleeping difficulties?	____	____

If yes, please describe: _____

How many hours a night does your child typically sleep? _____

Does your child have the opportunity to play with same-age children? ____ ____

What toys or activities does your child seem to enjoy? _____
_____
_____

Do/Did you have problems with your child in the preschool years because the child…

	Yes	No
Frequently ran off, was hard to keep track of?	____	____
Wouldn't stay at the table to eat or play a game?	____	____
Was unusually excitable so that you dreaded to take the child anywhere?	____	____
Had temper tantrums beyond the age of 4?	____	____
Was destructive to toys or household goods?	____	____
Set fires or played persistently with matches?	____	____
Was very demanding and demands had to be met at once?	____	____
Was unusually withdrawn?	____	____
Was unusually aggressive, would bite, scratch, hit, or kick on slight or no provocation?	____	____
Has unusual body movements like rocking?	____	____
Head banging?	____	____
Repetitive blinking?	____	____
Ticks or Twitches?	____	____
Is your child involved in any organized activities, such as sports, clubs, or lessons?	____	____

IV. Medical History

	Yes	No
Does your child have any disease or medical condition?	____	____

If yes, describe: _____
_____

Does your child take any medication regularly?	____	____

If yes, describe: _____
_____

Does your child have allergies? ____ ____
If yes, describe: _____
Has vision been checked? Yes ___ No ___
Date _____ Results_____
Has hearing been checked? Yes___ No____
Date_____ Results_____
Does your child have a history of ear infection? Yes ___ No ____
If yes, describe: _____
_____

Has your child ever been hospitalized? ____ ____
If yes, please list ages and reasons: _____
_____

Has your child ever had surgery? ____ ____
If yes, please list ages and reasons: _____
_____

Has your child ever had any serious accidents? ____ ____
If yes, please describe, including ages: _____
_____

Has your child ever had seizures or convulsions? ____ ____
If yes, please describe, including ages and medication if prescribed: _____
_____

Has your child ever had any head injuries? ____ ____
If yes, what happened and when? _____
_____

Is there any other important medical information? ____ ____
If yes, describe: _____
_____

Date of last physical examination? _____

Is your child left-handed_____ right-handed_____ ambidextrous_____

Is there a family history of left-handedness? _____ Ambidextrousness_____

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Thank you for taking the time to complete this questionnaire. It will help me in evaluating your child.