

Susan Weltner-Brunton, Ph.D. & Associates, Inc.

921 Chatham Lane, Suite 112

Columbus, Ohio 43221

Phone 614-754-7648

Fax 614-754-7965

An Association of Independent Practitioners

Susan Weltner-Brunton, Ph.D.

Laura L. Williams, Ph.D.

Sabrina Chow, Ph.D.

Alissa Shrader, MSW, LISW-S

Avalon Espinoza, MSW, LISW-S

Nadiya Timperman, MS, MPH, RD, LD

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 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

Was prenatal care received? Yes No

Were cigarettes consumed during pregnancy? Yes No

If yes, how many packs a day? _____

Was alcohol consumed during pregnancy? Yes No

If yes, how many days per week on average? _____

Were any drugs not prescribed by a doctor during pregnancy?
(such as marijuana, cocaine, speed, heroine, others)?

Yes No

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: _____	_____	_____

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? _____

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