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Psychotherapy and Mental Health Services
For Lifelong Wellness
301-793-1520
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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…
  - o Colds
  - o Gastrointestinal problems
  - o Headaches
  - o 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

Has your child ever hit his/her head?
Has your child ever been hospitalized overnight?

- ☐ 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

Condition for which hospitalized
Date
Length of hospitalization

Name of pediatrician _____

Is your child currently on any medications or dietary supplements?

Does your child have any vision problems?
Does your child wear glasses?
Contact lenses?

Glasses/lenses prescribed?
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:

Medication and dosage

Diagnosis

Prescribing physician

Date of initial prescription

Child walked:
□ <12months □ 12-24 months □ 24-36 months □ >36months □ has never walked

Child first trained for urination:
□ <12months □ 12-36months □ 3-5 years □ >5years
□ not yet trained

Since initial toilet training:
□ Frequent wetting duringday □ Frequent wetting during night

Child spoke words:

Child spoke sentences:
□ < 12 months □ 12-24 months □ 24-36 months □ > 36 months □ has never spoken sentences
□ □ □ □ □
< 12 months 12-24 months 24-36 months > 36 months has never spoken words

Child first trained for bowels:
- ◻ <12months
- ◻ 12-36months
- ◻ 3-5 years
- ◻ >5years
- ◻ not yet trained

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):
◻ <10years ◻ 10-12years ◻ 12-14 years

Educational
◻ 14-16years ◻ >16years ◻ not yet developed
List all schools your child has attended, beginning with the most recent:

(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:

Below grade level
On grade level
Above grade level

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:

School:

Grade:
Date of entry:

Date of Withdrawal:

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)

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.)

Please indicate 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
□ Autism Spectrum Disorders □ Learning Disabilities □ MentalRetardation □ Birth Defects
□ Cancer □ Diabetes □ Attention Deficit Hyperactivity Disorder (ADHD) □ Alcoholism □ Drug addiction □ Depression □ BipolarDisorder
□ Suicide (threats/attempts/completed) □ Anxiety
□ Phobias(specify) □ Psychiatric Hospitalizations □ High Blood Pressure □ High Cholesterol
□ Heart Disease

Relationship to Child *(specify maternal or paternal and relationship)*
_____
_____

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
- ☐ 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

Name of person completing this form , relationship to child, and date