

**THE FAMILY CENTER  
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:

- |  |  |
|--|--|
| <input type="checkbox"/> Adverse drug reactions        | <input type="checkbox"/> Chickenpox          |
| <input type="checkbox"/> Allergies (specify: _____)    | <input type="checkbox"/> Measles             |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Mumps               |
| <input type="checkbox"/> Frequent/recurring...         | <input type="checkbox"/> Substance abuse     |
| <input type="radio"/> Colds                            | <input type="checkbox"/> Surgeries, such as: |
| <input type="radio"/> Gastrointestinal problems        | <input type="radio"/> Appendectomy           |
| <input type="radio"/> Headaches                        | <input type="radio"/> Heart surgery          |
| <input type="radio"/> High fevers                      | <input type="radio"/> Tonsillectomy          |
| <input type="radio"/> Influenza                        | <input type="radio"/> Other (specify: _____) |
| <input type="radio"/> Migraine headaches               | <input type="checkbox"/> Arthritis           |
| <input type="radio"/> Pneumonia                        | <input type="checkbox"/> Cancer              |
| <input type="radio"/> Seizures                         | <input type="checkbox"/> Cerebral palsy      |
| <input type="radio"/> Sinusitis                        | <input type="checkbox"/> Diabetes            |
| <input type="radio"/> Sore throats                     | <input type="checkbox"/> Diphtheria          |
| <input type="radio"/> Strep throat                     | <input type="checkbox"/> Encephalitis        |
| <input type="checkbox"/> Broken bones (specify: _____) | <input type="checkbox"/> Exposure to lead    |
| <input type="checkbox"/> Dizziness/ Fainting           | <input type="checkbox"/> Meningitis          |
| <input type="checkbox"/> High/Low blood pressure       | <input type="checkbox"/> Polio               |
| <input type="checkbox"/> Insertion/removal of tubes    | <input type="checkbox"/> Tuberculosis        |

Has your child ever hit his/her head? \_\_\_\_\_

Has your child ever been hospitalized overnight? \_\_\_\_\_

Condition for which hospitalized	Date	Length of hospitalization

Name of pediatrician \_\_\_\_\_

Is your child currently on any medications or dietary supplements? \_\_\_\_\_

Medication and dosage	Diagnosis	Prescribing physician	Date of initial prescription

Does your child have any vision problems? \_\_\_\_\_ Does your child wear glasses? \_\_\_\_\_

Contact lenses? \_\_\_\_\_ Glasses/lenses prescribed, but child does not wear \_\_\_\_\_

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:

##### **Child walked:**

- < 12 months
- 12-24 months
- 24-36 months
- > 36 months
- has never walked

##### **Child spoke words:**

- < 12 months
- 12-24 months
- 24-36 months
- > 36 months
- has never spoken words

##### **Child spoke sentences:**

- < 12 months
- 12-24 months
- 24-36 months
- > 36 months
- has never spoken sentences

##### **Child first trained for urination:**

- < 12 months
- 12-36 months
- 3-5 years
- > 5 years
- not yet trained

##### **Child first trained for bowels:**

- < 12 months
- 12-36 months
- 3-5 years
- > 5 years
- not yet trained

##### **Since initial toilet training:**

- Frequent wetting during day
- Frequent wetting during night

##### **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):**

- < 10 years
- 10-12 years
- 12-14 years
- 14-16 years
- > 16 years
- not yet developed

**Educational**

List all schools your child has attended, beginning with the most recent:

School	Grade	Date of entry	Date of Withdrawal

(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:

Subject	Below grade level	On grade level	Above grade level
Language Arts/Reading			
Mathematics			
Writing			

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 \_\_\_\_\_

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)

Name	Relationship	Date of Birth	Occupation/School & Grade

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.)

Name	Place of Residence	Frequency of visits

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**

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

- Autism Spectrum Disorders
  - Learning Disabilities
  - Mental Retardation
  - Birth Defects
  - Cancer
  - Diabetes
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Alcoholism
  - Drug addiction
  - Depression
  - Bipolar Disorder
  - Suicide (threats/attempts/completed)
  - Anxiety
  - Phobias (specify \_\_\_\_\_)
  - Psychiatric Hospitalizations
  - High Blood Pressure
  - High Cholesterol
  - Heart Disease
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## **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

**Social** (cont'd)

- 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

**ADDITIONAL COMMENTS**

---



---



---



---



---



---

Person completing this form \_\_\_\_\_

Relationship to client \_\_\_\_\_

Referred by \_\_\_\_\_

***Thank you for taking the time to complete this questionnaire thoroughly!***

***The Family Center***