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 Release 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…
  - ○ Colds
  - ○ Gastrointestinal problems
  - ○ Headaches
  - ○ 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
- ☐ 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

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 _____

Phone Number_____

Email_____

Will you grant permission for us to consult with this professional? _____

(If yes, please sign attached Release Form)

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: _____ _____

Stressful Events

Stressful life events experienced by children and teens can have a profound affect on their physical and mental health. This questionnaire can assist your healthcare provider in assessing

these stresses. Please read each statement below and indicate whether it applies to you or your child/teen:

A person in the household often or very often acted in a way that made the child/teen afraid they would be hurt (e.g., sworn at, insulted, put down, humiliated) □YES □NO

A person in the household often hit, pushed, grabbed, or slapped the child/teen so hard that they had marks or were injured □YES □NO

A person touched the child/teen's private parts or asked them to touch their private parts □YES □NO

Child/teen often or very often expressed that people they lived with did not love them, look out for each other, feel close to each other, or were a source of strength and support □YES □NO

Child/teen often did not have enough to eat or clean clothes to wear, and did not have someone to take care of and protect them □YES □NO

Child/teen's parents or guardians were often absent due to separation, divorce or death □YES □NO

Child/teen witnessed a person in the household being pushed, grabbed, hit, or physically threatened □YES □NO

Someone the child/teen lived with had a problem with drinking or used street drugs □YES □NO

Someone the child/teen lived with was depressed, mentally ill or attempted suicide □YES □NO

Someone the child/teen lived with served time in prison □YES □NO

*Adapted from Centers for Disease Control & Prevention (2016) *

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