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Child/Family Questionnaire

Today's Date: ______________ Name/relationship of adult completing form: ________________________________

Child's Name: ______________________________ Date of Birth: ______________ Age: __________________

Religion: ____________________ Attend Church: Y or N How often: ______________________________

Birthplace: ________________________ Current School: ________________________ Grade: _______________

Previous Schools Attended: ____

What is the main reason you are seeking help at this time: ____

____

How long has this been a problem?: ____

Why did you decide to seek help at this time?: ____

Has your child received treatment for this problem or any other problem in the past?: Y or N

If yes: Name/Address of Professional: ____

Date of treatment: ____

Reason for treatment: ____

(use back side of page for additional providers)

Has your child ever received psychological, neurological, or educational testing? Y or N

If yes: Name/Address of Professional: ____

Date of treatment: ____

Reason for treatment: ____

(use back side of page for additional providers)

Is child adopted?: Y or N If yes: When?: ____________ Does child know?: __________________________

Please explain: ____

____

Has child ever lived away from family?: Y or N If yes, give dates and reason?: __________________________

____

Is child a twin?: Y or N Has child had contact with the police?: Y or N If yes, please describe circumstances: ____

List everyone closely involved with your child, not living in your home:

Name	Relationship	Place of Residence

If child is not currently living with both biological parents:

Is either parent deceased?: Y or N If yes, please give date and circumstance: ____________________________

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Were biological parents married? Y or N If yes, please give date: ________________________

Are biological parents separated/divorced? Y or N If yes, please give date: ________________________

Who financially supports your child?: ______________ Child Support?: ________________________

How would you describe your child as a person?: ________________________

____

How is your child doing in school? Progress/Grades? Retained? Behavioral Issues?:

____

____

____

____

Does your child have many friends? ________________________

Does your child have difficulty making/keeping friends?: ________________________

Does your child have difficulty with his/her brothers or sisters? ________________________

Family Concerns: Mark X if applicable:

Marital Difficulties: ___ Death in Family: ____ Aging Grandparents: ____ Alcoholism: ____Drug Addiction: ______

Financial Problems: _____ Single Parent: ____ Divorce: _____ High Conflict Divorce: ____ Serious Illness: ______

Birth of New Child: ____ Job Loss: _____ Other (please specify): ________________________

Briefly describe any hobbies or recreational activities family members participate in:

Name Activity

____

____

____

Pregnancy, Birth and Delivery:

Did you have any complications with your pregnancy? Y or N If yes, please explain:

____

____

Was your child premature? Y or N If yes, how many weeks premature? ______ Were there any complications with delivery? Y or N If yes, please explain. ________________________

____

Did you consume alcohol, smoke cigarettes, or use substances while pregnant? Y or N If yes, please explain: ____

____

Child Development:

Age when child crawled: ___________ Took first steps: ______________ Spoke first words: _____________

Spoke in full sentences: ____________ First trained for urination: ____________ First trained for bowels: ________

Dry during the day: ____________ Dry during the night: _____________ Onset of puberty (breast development, menstruation, pubic hair, facial hair): _______ Did you feel your child was developmentally on target:____________

Any concerns with fine motor skills?________ Any concerns with gross motor skills? ____________

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Does your child have a hyper or hypo sensitivity to touch or sound? ____

Sleep Patterns:

Has your child ever had nightmares? Y or N If yes, please explain: ______________________________________

___

Has your child ever had night terrors? Y or N If yes, please explain: ______________________________________

___

Has your child ever sleepwalked? Y or N If yes, please explain: ______________________________________

___

Does your child have difficulty falling asleep or staying asleep? Y or N If yes, please explain:

___

Has your child ever suffered from enuresis or encopresis? Y or N If yes, please explain: ____________________

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History of Family Illness: Put an **F** for a family history and a **C** for an illness your child currently or has previously been treated for.

Asthma:____ Tuberculosis:____ Dizziness:______ Eczema:______ Meningitis:________
Arthritis:______ Influenza:_______ Broken Bone:______ Pneumonia:_____ Diabetes:__________
Cancer:_______ Migraines:______ Anemia:______ Undescended testicles:_______
Measles:______ Mumps:_____ High Blood Pressure:_______ Low Blood Pressure:_____ High Cholesterol:____
Chicken Pox:_____ Sinusitis:______ Diphtheria: _______ Appendicitis:_______ Scarlet Fever:________
Heart Surgery:_______ Polio:_______ Tonsillectomy:_________ Cerebral Palsy:_____ Seizures:______
Brain Injury:____ Encephalitis:______ Fainting:_______ Lead Poisoning:____Depression:______ Suicide:________
Schizophrenia:________ Bipolar Disorder:_______ Anxiety:________ Other:________________________________

List any hospitalizations your child has had:

Condition Age Length of hospitalization

___

___

___

Child's Play Habits:

What is your child's favorite play thing? ____

How long does your child play with one toy?____

Is your child responsible for keeping his/her toys in order?____

Does your child play with the toy or take it apart?____

Does your child collect anything?____

Does your child have a favorite game? What is it?____

How does your child play the game? Does he/she finish it? Can he/she lose without getting upset? _______________

___

If your child is given a choice, what would he/she choose to do or play with?___________________________________

How much time does your child watch TV? What is his/her favorite program?_________________________________

Does your child play video games? How much time do they spend playing?___________________________________

Does your child like to draw or color?____

Does your child join in with others when at the playground?____

Would your child prefer to play alone or with others?____

What sports, if any, does your child play?____

Please include anything else you think is important to know about your child and family:

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