Background Questionnaire

Child's Name: _____Gender: _____ Date of Birth: _____ Referral Date: _____

Person Completing Form: _____ Relationship to Child: _____

Child's Home Address: _____

Phone Number: (Home)_____ (Cell) _____

Who referred you here? Name: _____ Agency: _____

Main Concerns: _____

_____

Is the child adopted? ☐ Yes** ☐ No Is the child in foster care? ☐ Yes** ☐ No

Copies of any custody agreements or relevant Court Orders of who has medical rights will need to be provided so that we know who is entitled to receive records and information. Information is required before an appointment conducted.

Child's Ethnicity:
___ Hispanic/Latino ____Non-Hispanic/Latino

Child's race: (Please mark "multi-cultural" if a child is more than one race)

____Caucasian or white ____African American or Black ____Asian, including South Asian or Indian

____Native Hawaiian or Pacific Islander ____Native American Indian, Native Alaskan or Inuit

Multicultural/Other: Please specify _____

FAMILY HISTORY

	Biological Mother	Biological Father	Legal Guardian
Name:	_____	_____	_____
Age:	_____	_____	_____
Address:	_____	_____	_____
City, State, Zip	_____	_____	_____
Years of Education:	_____	_____	_____
Learning Problems:	_____	_____	_____
Current Occupation (job):	_____	_____	_____
Emotional Problems:	_____	_____	_____
Substance Abuse:	_____	_____	_____
Medical Problems:	_____	_____	_____
Genetic Testing:	_____	_____	_____
Does this person live with the child?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Are the biological parents: ☐ Married ☐ Together ☐ Separated ☐ Divorced ☐ Never Married

If the parents are remarried or live with a significant other, please provide information:

Name: _____ Name: _____
Age: _____ Age: _____
Relationship: _____ Relationship: _____
Current Occupation (job): _____ Current Occupation (job): _____
How long has person known child: _____ How Long has person known child: _____

Please list the siblings (Full, Half, Step, Adoptive/Foster) of the child and circle the names of those who live with the child.

Name	Age	Relationship	Grade/Job	Learning, emotional, or medical problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List anyone *who lives in the household* who is **NOT** a parent, guardian or sibling, and the *relationship* to the child:

_____
_____

Please list anyone in the family who has had any medical problems, mental health diagnoses, or substance abuse issues.

_____
_____
_____

PREGNANCY, BIRTH, AND DEVELOPMENTAL HISTORY

Mother's age at child's birth: _____ Father's age at child's birth:_____

While pregnant, what medications (prescribed or over-the-counter) did the mother take:_____
_____
_____

Any health problems during pregnancy?_____

Did the mother receive regular prenatal care? ☐ Yes ☐ No

Was the child delivered: ☐ Vaginally ☐ Cesarean Section

Did the mother use any of the follow substances during pregnancy?

☐ None ☐ Caffeine ☐ Tobacco ☐ Alcohol
☐ Marijuana ☐ Other Drugs (Cocaine, Heroin, etc.)

Was child born: ☐ Early: _____ ☐ On time (37-42 weeks):_____ ☐ Late:_____

How much did the child weigh at birth? _____lbs. _____oz.

Did the mother have any problems with delivery? ☐ Yes ☐ No
If so, please describe: _____

Did the child have any problems during the first year of life? ☐ Yes ☐ No

If so, please describe: _____

_____

Motor Skills

Crawled forward:	☐ Early	☐ Average (8-10mnth)	☐ Late	☐ Not Yet
Walked alone (2-3 steps):	☐ Early	☐ Average (11-13mnth)	☐ Late	☐ Not Yet

Language abilities

Said "dada" or "mama":	☐ Early	☐ Average (11-14mnth)	☐ Late	☐ Not Yet
Said other single words":	☐ Early	☐ Average (12-14mnth)	☐ Late	☐ Not Yet
Used two-word sentences:	☐ Early	☐ Average (20-24mnth)	☐ Late	☐ Not Yet

Does your child have toileting issues? _____

HEALTH HISTORY

What hand does the child use most? ☐ Right ☐ Left ☐ Use both equally

Has your child's vision been tested? ☐ Yes ☐ No

If yes, what were the results? _____

Corrective lenses? ☐ Yes ☐ No

Has your child's hearing been tested? ☐ Yes ☐ No

If yes, what were the results? _____

Was the child ever admitted to a hospital? ☐ Yes ☐ No

If so, please describe: _____

Has the child had/have any medical problems? ☐ Yes ☐ No

Describe: _____

Does the child take any medications (prescribed or over-the-counter) currently? ☐ Yes ☐ No

If so, please list what he/she takes, how much, when and why:

Start Date	Medication Name	Dosage	When Taken	Why

Who provides medication management for the child (include name and practice)?

_____

Name of Primary Care Physician/Pediatrician: _____

Address:_____

Specialists Seen: ☐ Developmental Pediatrician ☐ General Pediatrician ☐ Endocrinologist ☐ Cardiologist
☐ Other: _____

What therapies have been provided to the child (Please list when and by whom):

☐ No therapies ☐ Occupational Therapy: _____
☐ Physical Therapy: _____ ☐ Speech Therapy: _____
☐ Psychotherapy or counseling: _____ ☐ Other: _____

If any, what evaluations has the child had, and when?

☐ Neurological examination or imaging: _____
☐ Psychiatric / Medication Evaluation: _____ ☐ Psychological or neuropsych testing: _____
_____ _____
☐ Speech and language testing: _____ ☐ School testing/Educational Assessment: _____
_____ _____

Does the child have any current mental health diagnoses (List Below)? ☐ Yes ☐ No

Diagnosis	Professional/Institution providing diagnosis
_____	_____
_____	_____
_____	_____

SCHOOL HISTORY

Name of School District: _____

Name of present school: _____ Current Grade: _____

Was the child ever held back to repeat a grade? ☐ No ☐ Yes Which Grade? _____

Is the child in special education? ☐ No ☐ Yes Beginning When: _____

Does the child have: _____IEP _____ 504 Plan

Class Type: Regular classroom Learning Support Autism Support Emotional Support

What kind of grades has the child earned in the past year? (Check all that apply)

☐ A ☐ B ☐ C ☐ D ☐ F

or

☐ Outstanding ☐ Good ☐ Satisfactory ☐ Improvement Needed ☐ Unsatisfactory

Signature Date

****If your child has had testing (Educational or Psychological/Neuropsychological) performed by a School Psychologist, or by a psychologist/neuropsychologist, it is imperative that you bring the reports with you.****