



Completion Format: Questionnaire Interview

Interviewer's / Clinician's Name _____ Date _____

Child's Name _____ Sex F M

Address _____ Phone _____

_____ Birth Date _____

School _____ Age _____

Teacher _____ Grade _____

What is this child's primary language? _____ Is this referral related to any type of legal or court proceeding? No Yes

What is this child's secondary language? _____

DIRECTIONS: To the best of your ability, please answer all of the questions, even if some do not seem to apply. If you do not understand an item, please ask the person who gave you this form, to help you.

PERSON ANSWERING QUESTIONS

NOTES

Name _____

Relationship to This Child _____

Address _____

Home Phone _____ Work Phone _____

REFERRAL INFORMATION

Why are you seeking help for this child? _____

Who referred you to our service? _____

What kind of services are you seeking for this child (for example, change of school placement, therapy, psychological testing, custody evaluation, etc.)? _____

PARENTS

Mother's Name _____ Stepmother? No Yes

Address _____ Age _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

How long with present employer? _____ Highest Grade Completed _____

Primary Language _____ Secondary Language _____

Father's Name _____ Stepfather? No Yes

Address _____ Age _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

How long with present employer? _____ Highest Grade Completed _____

Primary Language _____ Secondary Language _____

Does this child have other parent(s)/stepparent(s)? No Yes *If yes, please provide the following information.*

Name _____ Age _____

Relationship to This Child _____ Home Phone _____

Address _____

Name _____ Age _____

Relationship to This Child _____ Home Phone _____

Address _____

PRIMARY CAREGIVERS

With what adult(s) does this child live? _____

How long in current living situation? _____

Please provide the following information about primary caregivers, if not given previously.

Name _____ Relationship to Child _____

Address _____ Age _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

How long with present employer? _____ Highest Grade Completed _____

Primary Language _____ Secondary Language _____

Name _____ Relationship to Child _____

Address _____ Age _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

How long with present employer _____ Highest Grade Completed _____

Primary Language _____ Secondary Language _____

CHILD CARE

If primary caregivers work outside the home, please provide the following information.

Who cares for this child when caregivers are gone? _____

How many hours per day is this child in a child-care setting? _____

How many different people care for this child? (Please explain.) _____

FAMILY HISTORY

Is this child closer to one parent than the other? No Yes If yes, which? _____

Has this child ever experienced any parental separations, divorces, or death? No Yes

If yes, when? _____ How old was this child at the time? _____

Please describe the circumstances. _____

If the parents are separated or divorced, who has custody of this child? _____

How often does the other parent see this child? (check one)

- Weekly or More Often
- Often or Twice a Month
- Few Times a Year
- Never

BROTHERS/SISTERS

Please list all brothers and sisters, and any other children living with the family.

Age	Sex	Relationship to This Child	Living at home?
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How does this child get along with brother(s) and/or sister(s)? _____

CHILD'S RESIDENCE (check one)

- Apartment
- Single Home
- Other _____
- How long at current address _____

FAMILY RELATIONS

NOTES

Check the activities in which this child often participates with the family.

- Movies Meals Conversations Visits with Relatives Church
 Games Sports Trips Television Other

Language Spoken in the Home _____

How frequently does this child see grandparents? (check one)

- Weekly or More Often Once or Twice a Month Few Times a Year
 Never No Grandparents Living

What do you enjoy most about this child? _____

What do you find most difficult about raising this child? _____

What would you like this child to be when he/she grows up? _____

What level of education do you hope this child will complete? (check one) High School

- Technical or Vocational School College Law, Medical, Other Advanced Studies

Who is mainly in charge of discipline in the home? _____

Do all caregivers agree on discipline? _____

Describe discipline techniques. _____

PREGNANCY

Was this child a planned pregnancy? No Yes

Was the mother under a doctor's care? No Yes

Number of Previous Pregnancies/Miscarriages _____

Check any of the following complications that occurred during the pregnancy.

- Difficulty in Conception Toxemia Abnormal Weight Gain
 Measles Excessive Vomiting German Measles
 Excessive Swelling Emotional Problems Vaginal Bleeding
 Flu Anemia High Blood Pressure
 Other (Rh Incompatibility, etc.) _____
 Maternal Injury: Describe _____
 Hospitalization During Pregnancy: Reason _____
 X-Rays During Pregnancy: What Month? _____
 Medications Used During Pregnancy: What Kind?

Alcohol Used During Pregnancy: Frequency _____

Cigarettes Used During Pregnancy: Frequency _____

Other Drugs Used During Pregnancy:

Type	Frequency	Prescription	
		No	Yes
_____	_____	_____	_____

BIRTH

At this child's birth, what was the mother's age? _____ Father's Age? _____

Mother's age at birth of first child? _____

Was this child born in a hospital? Yes No If no, where? _____

Length of Pregnancy: _____ weeks Birth Weight: _____ lbs _____ oz

Length of Labor: _____ hours Apgar Score _____

Child's Condition at Birth _____

Mother's Condition at Birth _____

Check any of the following complications that occurred during birth.

Forceps Used Breech Birth Labor Induced Caesarean Delivery

Other Delivery Complications: Describe _____

Incubator: How Long? _____

Jaundiced: Bilirubin lights? No Yes If yes, how long? _____

Breathing Problems Right After Birth: Describe _____

Supplemental oxygen No Yes If yes, how long? _____

Was anesthesia used during delivery? No Yes If yes, what kind? _____

Length of Stay in Hospital: Mother: _____ days Child: _____ days

DEVELOPMENT

At what age did this child first do the following? Please indicate year/month of age.

_____ Turn Over _____ Walk down stairs _____ Sit Alone

_____ Show Interest in or Attraction to Sound _____ Crawl _____ Stand Alone

_____ Understand First words _____ Speak First words _____ Walk Alone

_____ Speak in Sentences _____ Walk up Stairs

Was this child breast-fed? No Yes When weaned? _____

Was this child bottle-fed? No Yes When weaned? _____

When was this child toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? No Yes If yes, until what age? _____

Did bed-soiling occur after toilet training? No Yes If yes, until what age? _____

Were there any medical reasons for bed-wetting or bed-soiling? No Yes Please describe:

Has this child experienced any of the following problems? If yes, please describe.

Walking Difficulty No Yes _____

Unclear Speech No Yes _____

Feeding Problem No Yes _____

Underweight Problem No Yes _____

Overweight Problem No Yes _____

Colic No Yes _____

Sleep Problem No Yes _____

Eating Problem No Yes _____

Difficulty Learning to Ride a Bike No Yes _____

Difficulty Learning to Skip No Yes _____

Difficulty Learning to Throw or Catch No Yes _____

During this child's first 4 years, were any special problems noted in the following areas? Describe.

Eating No Yes _____

Motor Skills No Yes _____

Sleeping Too Much No Yes _____

Temper Tantrums No Yes _____

Sleeping Too Little No Yes _____

Failure to Thrive No Yes _____

Separating from Parents No Yes _____

Excessive Crying No Yes _____

Which hand does this child use for writing or drawing? _____ Eating? _____

Other (throwing, etc.)? _____ Has this child been forced to change writing hand? No Yes

MEDICAL HISTORY

Childhood illnesses/injuries Please check the illnesses this child has had and indicate age (yr/mo)

Measels _____ Rheumatic Fever _____ German Measles _____ Diphtheria _____

Mumps _____ Meningitis _____ Chicken Pox _____ Encephalitis _____

Anemia _____ Tuberculosis _____ Whooping cough _____ Fever Above 104 _____

Scarlet Fever _____ Broken Bones _____ Head Injury: Describe _____

Comas or Any Loss of Consciousness: Describe: _____

Sustained High Fever: Describe: _____

Please describe other serious illnesses or operations:

Illness/Operation

Age

Has this child ever been on any medication for 6 months or more? No Yes

If yes, when? _____ What kind? _____

Please indicate whether this child currently has any of the following problems. If yes, how often?

RESPIRATORY

Frequent Colds No Yes _____

Chronic Cough No Yes _____

Asthma No Yes _____

Hay Fever No Yes _____

Sinus Condition No Yes _____

Cardiovascular

Shortness of Breath or Dizziness with Physical Exertion No Yes _____

Activity Limitation Due to Heart Condition No Yes _____

Heart Murmur No Yes _____

GASTROINTESTINAL

Excessive Vomiting No Yes _____

Frequent Diarrhea No Yes _____

Constipation No Yes _____

Stomach Pain No Yes _____

GENITOURINARY

Urination in Pants/Bed No Yes _____

Pain While Urinating No Yes _____

Excessive Urination No Yes _____

Strong Odor to Urine No Yes _____

MUSCULOSKELETAL

Muscle Pain No Yes _____ When? _____ Where? _____

Clumsy Walk No Yes _____

Poor Posture No Yes _____

Other Muscle Problems No Yes If yes, describe: _____

SKIN

NOTES

Frequent Rashes No Yes _____

Bruises Easily No Yes _____

Sores No Yes If yes, describe: _____

Severe Acne No Yes _____

Itchy Skin (Eczema) No Yes _____

NEUROLOGICAL

Seizures/Convulsions No Yes If yes, describe: _____

Speech Defects No Yes _____

Accident Prone No Yes _____

Bites Nails No Yes _____

Sucks Thumb No Yes _____

Grinds Teeth No Yes _____

Has Tics/Twitches No Yes _____

Bangs Head No Yes _____

Rocks Back and Forth No Yes _____

Bowel Movements in Pants/Bed No Yes _____

Has this child ever taken medication to increase activity? No Yes

If yes, when? _____ What medication? _____

Has this child ever taken tranquilizing medication? No Yes

If yes, when? _____ What medication? _____

Has this child ever taken medication for ADD, ADHD, or similar problems? No Yes

If yes, when? _____ What medication? _____

ALLERGIES

Allergy to Medicine No Yes If yes, describe _____

Allergy to Food No Yes If yes, describe _____

Other Allergies No Yes If yes, describe _____

SPEECH

Stuttering No Yes _____

Unclear Speech No Yes _____

Other Speech Problem No Yes _____

Date of Most Recent Speech Exam _____

HEARING

NOTES

Ear Infections No Yes _____

Hearing Problems No Yes _____

Ear Tubes No Yes _____

Date of most Recent Hearing Exam _____

VISION

Vision Problems No Yes _____

Wears Glasses or Contacts No Yes _____

Date of Most Recent Vision Exam _____

MEDICAL CARE

Child's Physician _____ Telephone _____

How often does this child see a doctor? _____ Date of Last Visit _____

Is this child currently on medication? No Yes

 If yes, indicate type and reason _____

Has this child ever been physically or sexually abused? No Yes

 If yes, please discuss this issue with the person who gave you this form to complete.

Has this child ever had psychological counseling or therapy? No Yes

 If yes, counselor's name _____

 Address _____

 Telephone _____

 Type of Counseling _____

 When? _____

Has this child ever had a neurological exam? No Yes

 If yes, neurologist's name _____

 City _____ Date of Exam _____

 Reason for Exam _____

Has this child ever had a psychological or psychiatric exam? No Yes

 If yes, doctor's name _____

 City _____ Date of Exam _____

 Reason for Exam _____

FAMILY HEALTH

Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents, if known.

- Cancer _____ High Blood Pressure _____
- Cystic Fibrosis _____ Kidney Disease _____
- Diabetes _____ Migraine Headaches _____
- Physical Handicap _____ Alcohol/Drug Abuse _____
- Stroke _____ Behavior Disorder _____
- Tuberculosis _____ Emotional Disturbance _____
- Alzheimer's Disease _____ Mental Illness _____
- Hemophilia _____ Mental Retardation _____
- Huntington's Chorea _____ Nervousness _____
- Muscular Dystrophy _____ Seizures or Epilepsy _____
- Parkinson's Disease _____ Reading Problem _____
- Sickle-Cell Anemia _____ Other Learning Disability _____
- Tay-Sachs Disease _____ Speech or Language Problem _____
- Tourettes Syndrome _____ Food Allergies _____
- Birth Defect _____ Severe Head Injury _____
- Cerebral Palsy _____ Other: Describe: _____

Describe father's present health. _____ Mother's _____

Has anyone in the family ever been in special education? No Yes

If yes, who? _____ What type of Class? _____

FRIENDSHIPS *Please indicate how this child relates to other children.*

Has Problems Relating to or Playing with Other Children. No Yes _____

Fights frequently with Playmates No Yes _____

Prefers Playing with Younger Children No Yes _____

Has Difficulty Making Friends No Yes _____

Prefers to Play Alone No Yes _____

Are there children in the neighborhood with whom this child could play? No Yes _____

What role does this child take in peer group games (for example, leader, follower, etc.)? _____

Please indicate whether any of this child's friends engage in any of the following behaviors.

Smoke Cigarettes No Yes Chew Tobacco No Yes
 Inhale Toxic Substances (e.g. ,paint) No Yes Drink beer, wine, or liquor No Yes
 Use Illegal Drugs (e.g., marijuana, cocaine) No Yes

RECREATION/INTERESTS

What activities does this child enjoy?

Sports: _____

Hobbies: _____

Other: _____

Has this child's interest in participating in these activities declined recently? No Yes

If yes, describe. _____

BEHAVIOR/TEMPERAMENT

Please indicate whether this child exhibits any of the following behaviors.

Is Easily Overstimulated in Play No Yes Seems Overly Energetic in Play No Yes

Has a Short Attention Span No Yes Seems Impulsive No Yes

Lacks Self-Control No Yes Overreacts When Faced with a Problem No Yes

Seems Unhappy Most of the time No Yes

Seems Uncomfortable Meeting New People No Yes Withholds Affection No Yes

Requires a Lot of Parental Attention No Yes Cannot calm Down No Yes

Has Fears No Yes If yes, Describe _____

What makes this child angry? _____

EDUCATIONAL HISTORY

Preschool and Daycare

Does or did this child attend preschool/daycare? No Yes At what age? _____

Amount of Time per Day _____ Days per Week _____

Any Problems in preschool? No Yes If yes, describe _____

Does or did this child attend kindergarten? No Yes

Any Problems in kindergarten? No Yes If yes, describe _____

Elementary/High School Name of Child's School _____

District _____

Contact information _____

Please indicate whether this child has had any of the following school experiences.

Has Changed Schools for Reasons Other Than Normal Academic Progression No Yes

If yes, when and why? _____

Has Been Retained a Grade in School No Yes If yes, when and why? _____

Has Skipped a Grade in School No Yes If yes, when and why? _____

Has Difficulty with Reading No Yes If yes, describe. _____

Has Difficulty with Math No Yes If yes, describe. _____

Gets Poor Grades No Yes Describe most recent report card results. _____

Has Been Tested for Special Education No Yes If yes, when? _____

Currently Is Placed in Special-Education Class No Yes

If yes, what type of class? _____ Hours per Day _____

Dislikes Going to School No Yes

Is Absent from School Frequently No Yes If yes, why? _____

If in high school, when will this child graduate? _____

Do you have any concerns about the quality of this child's school or teachers? No Yes

If yes, describe _____

ADDITIONAL COMMENTS

