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CHILDREN'S HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your child's background. In scientific work, historical records are necessary, as they permit a more thorough and realistic developmental understanding of your child's current diagnosis. By completing these questions as fully and as accurately as you can, you will facilitate your child's therapeutic program. However, if there are any questions you feel are inappropriate to answer on paper, you may discuss them privately with the therapist.

Child's Name: _____ DOB: _____

Mother's Name: _____ Age: _____ Home Phone: _____

Address: _____

Work Phone: _____ Cell Phone: _____

Father's Name: _____ Age: _____ Home Phone: _____

Address: _____

Work Phone: _____ Cell Phone: _____

Stepparents' Names and Ages: _____

Have you sought guidance regarding these or similar problems in the past? ____ yes ____ no

If so, therapist's name and/or clinic: _____

When? _____ For how long? _____

Developmental History

1. Pregnancy and Delivery

a. Mother's health and mood compared with other pregnancies: _____

b. Was this pregnancy planned by both parents? _____

c. Birth weight and infant's health: _____

Completed by Second Session if Under Age 18

d. Any problems with pregnancy? ____ yes ____ no If yes, explain: _____

e. Any problems with perinatal events or use of drugs, tobacco, or substances during pregnancy?
____ yes ____ no If yes, explain: _____

2. Feeding and Nutrition

a. How long did mother nurse this baby?

b. How long did child use bottle/formula? _____

c. Any problems feeding child? ____ yes ____ no If yes, explain: _____

d. Fed on demand or on a schedule? _____

e. Current appetite and eating habits: _____

f. Any food allergies? ____ yes ____ no If yes, list: _____

3. Sleep Patterns

a. During the first year, what were your child's sleep patterns? _____

b. From birth to age 5, any nightmares, sleepwalking, or head-banging? ____ yes ____ no

c. From age 5 to now, describe any bed-wetting or other problems: _____

4. Motor Development and Speech

As closely as you can recall, at what age did your child first display the ability to:

a. Turn over in crib _____ b. Sit up with help _____

c. Stand alone _____ d. Walk without support _____

e. Speak any words _____ f. Speak in sentences _____

g. Current speech functioning: ____ poor ____ adequate ____ excellent

h. Stop wearing diapers during the day _____

i. Consistently sleep through the night without bed-wetting _____

Child's Name

5. Bowel and Bladder Training

- a. How was this training accomplished? _____
- b. Any recent problems? ____ yes ____ no If yes, what and when: _____

6. Physical Health

- a. List dates of significant illness, accidents, and hospitalizations: _____

- b. General health/handicaps or disabilities, including hearing, vision, or intellectual deficits:

- c. Allergies/adverse reactions (and current status): _____
- d. Current medication and dosage: _____
- e. Frequent colds, flu, fevers? ____ yes ____ no
- f. Any history of convulsions or seizures? ____ yes ____ no
- g. How does your child feel about his/her body? _____
- h. Are immunizations up to date? _____
- i. Any abuse, neglect, or violence issues? ____ yes ____ no If yes, please explain:

j. List all current medications and dosage. List below, for what problem, and how well they work.

<u>Name</u>	<u>Dose</u>	<u>Reason</u>	<u>How Long</u>	<u>Effectiveness</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ Child's Name

k. List all past medications, for what problem, and how well they work.

<u>Name</u>	<u>Dose</u>	<u>Reason</u>	<u>How Long</u>	<u>Effectiveness</u>
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7. Unusual Experiences or Crises

a. Deaths in the family or of friends or pets. How did child react? How old was child?

What was parental response to this crisis? _____

b. Other frightening events? If so, please describe event and child's response and age:

c. Have there ever been periods when your child seemed to stop developing or returned to more immature behavior? ____ yes ____ no If yes, describe situation and age: _____

8. Education and Employment

a. List schools attended from preschool to the present. Note any problems experienced:

b. Has your child been evaluated by a school psychologist or ever had an IEPC?

yes ____ no ____ If so, list date(s): _____

c. Have there been problems relating with teachers? yes ____ no ____ If yes, describe:

d. Name and phone number of current teacher: _____

e. Name and phone number of current school counselor or social worker: _____

Child's Name

f. Have there been problems relating with other children? yes ____ no ____ If yes, describe:

g. Has your child worked outside the home? _____

h. What are your child's responsibilities at home (chores, etc.)? _____

9. Relationships with Family and Community

a. How does your child relate with each parent? _____

b. Which parent does this child most resemble in terms of disposition: _____

Looks: _____ Attitude toward others: _____

c. How does father discipline this child? _____

d. How does mother discipline this child? _____

e. Which parent is most upset by this child's behavior? _____

f. Do any other adults outside of school spend regular time with this child? yes ____ no ____

If yes, who? _____

g. Describe relationship with brothers and sisters: _____

h. Describe child's best friends (first names, ages, etc.) _____

i. Any contacts with police or Protective Service? ____ yes ____ no If yes, describe:

j. How often has family moved? _____

k. In what groups does child participate? _____

l. Any religious participation? _____

m. How does child feel about therapy? _____

Child's Name

10. Family Background

Mother (or primary female caretaker, i.e. stepmother, grandmother, etc.):

- a. Where did you grow up? _____
- b. Ethnic, cultural, and religious background: _____

- c. Names/ages of your brothers and sisters: _____
- d. How did you get along with your parents and siblings as a child? How are these relationships now?

- e. How much contact do you and your child have with your side of the family? _____

Father (or primary male caretaker, i.e. stepfather, grandfather, etc.):

- a. Where did you grow up?

- b. Ethnic, cultural, and religious background: _____

- c. Names/ages of your brothers and sisters: _____
- d. How did you get along with your parents and siblings as a child? How are these relationships now?

- e. How much contact do you and your child have with your side of the family?

11. Substance Use (only applicable if age 12 or over)

Child's Name

Please check all that apply:

- a. Nicotine ____ b. Alcohol ____ c. Prescription medication ____ d. Illicit drugs ____
e. Over-the-counter medications ____ f. None of the above ____

Please describe any checked items:

12. In your own words, what do you see as your child's personal strengths, needs, abilities and/or interests and preferences?

Therapist's Formulation (summary of central themes, integration of all history and assessments, and clients' perceptions of strengths and needs):

Signature of Client or Parent

Date

Signature of Therapist

Date

March 2008
dla

Child's Name