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This questionnaire is to be filled out by a parent or guardian requesting services for a child.

Note: Information requested on this questionnaire will be helpful in the evaluation of the problem. Please fill it out carefully. Feel free to add as much information as you think may be helpful using the backs of pages if you wish.

Name of Child: _____ Date: _____

Address: _____

_____

Home Phone: _____ Date of Birth: _____

Age: _____ Sex: _____ Martial Status: _____

Education Level (child): _____

Describe your reasons for bringing the child to counseling:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is the child currently taking medicine? Yes ___ No ___ If yes, what? When? Why?

_____
_____
_____

Please describe if any children living in the house were adopted, if there have been previous marriages, if there have been any deaths in the immediate family, or if the child, before the age of 8, was separated from either parent for more than a week.

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime.

Name	Relationship to child	Age	Highest School Grade	Handedness (Right/Left/Both)	Occupation

If child lives with other than both biological parents, please complete same information on the back of this sheet for present parents and note relationship to child.

FAMILY BACKGROUND

Biological Mother's Family

Name	Present age or year of death and age at time	Education	Handedness (Right/Left/Both)	Occupation
Mother				
Father				
Brothers				
Sisters				

Biological Father's Family

Name	Present age or year of death and age at time	Education	Handedness (Right/Left/Both)	Occupation
Mother				
Father				
Brothers				
Sisters				

ILLNESS AND PROBLEMS OF FAMILY MEMBERS

Indicate below which family members listed on the last two pages as well as their children have had any of the following conditions or illness and describe what your know of their symptoms.

Trouble learning to read, write, spell, or do arithmetic: _____
_____

Behavioral problems as a child: _____
_____

Problems with speech or hearing: _____
_____

Problems with vision beyond needing ordinary glasses: _____
_____

Long-term physical illness or handicap: _____
_____

Trouble with the law: _____
_____

Drug or alcohol problems: _____
_____

Mental retardation: _____
_____

Epilepsy, fainting spells, or other neurological conditions: _____
_____

Allergies, asthma, hay fever: _____

High blood pressure or heart disease: _____
_____

Stomach ulcers: _____
_____

Unusual nervousness: _____
_____

“Blue” or mildly depressed much of the time: _____
_____

Severe depression, nervous breakdown, or mental illness: _____
_____
_____

MOTHER'S PREGNANCIES

List in order of birth. If ending in miscarriage, state at which month and why. If more than 3, note and continue on back.

Year	Length of Pregnancy (in weeks)	Birth	Weight	Sex	Complications

Pregnancy with referred child – check the following that apply.

Anemia ___ High Blood Pressure ___ Toxemia ___ Swollen Ankles ___ Kidney Disease ___
Heart Disease ___ Bleeding ___ German Measles ___ Virus ___ Excessive Weight Gain ___
Spotting ___ Underweight ___ Other illness or infections ___ Rh/other blood incompatibility __
Hospitalization ___ Operation ___ Vomiting ___ Threatened miscarriage/early contractions ___

List medications or drugs taken during pregnancy. Indicate how long and the reason why.
_____
_____
_____

Please explain any problems with delivery of referred child.
_____
_____
_____
_____
_____

Please explain any problem with the condition of the baby at birth and the first week of life.
_____
_____
_____
_____

Medical History:

List child's sicknesses, operations, and injuries. Indicate age when occurred and describe how severe. Please report all head injuries and any time when child was unconscious or had convulsions or was delirious or had a very high fever. Has the child been given medicine or drugs for nervousness, emotional, or behavioral problems before now (what, when, how long)?

_____
_____
_____
_____
_____
_____

DEVELOPMENT

How did the first year go: Colic? ___ Feeding Problems? ___ Taking solid food? ___ Sleeping problems? ___ Head banging? ___ Rocking? ___

Please describe the child as a baby:

_____
_____

Age sat alone: ___ Age tied shoes: ___ Age pedaled tricycle: ___ Age walked without holding on: ___ Age fed self: ___ Age rode bicycle: ___ Age dressed self: ___ Age swam: ___ Age first words: ___ Age spoke in sentences: ___ Age gave up bottle: ___ Days: ___ Nights: ___ Age gave up daily napping: ___

Toilet training: Urine – began training at age ___; dry days at age ___; dry nights at age ___. Bowels – began training at age ___; clear days at age ___. Was training easy ___ or difficult __?

Describe any problems:

_____
_____

Describe any problems with bowels or urine now:

_____
_____

Describe child's appetite and eating habits at present:

_____
_____

Describe child's level of activity and vigor:

_____
_____

Describe the child's requirements for and response to discipline:

_____

_____

To which forms of discipline does the child best respond?

_____

_____

Describe how child gets along with other children in the family:

_____

_____

Describe how child gets along with children not in the family: Leader? Follower? Playing with children who are older? younger?

_____

_____

Describe how the child expresses affection:

_____

_____

Describe any moody periods:

_____

_____

Describe any problems with awkwardness or clumsiness:

_____

_____

Describe any problems with lying or stealing:

_____

_____

Describe how anger is expressed:

_____

_____

Describe any problems with sexual behavior or sexual interest:

_____

_____

Describe how predictable the child appears to be: Any self-imposed rituals or routines or repetitions of behavior?

_____

_____

Describe any tendencies towards jealousy:

_____

_____

Describe any difficulty in looking people straight in the eye:

_____

_____

Describe how much attention the child seems to need:

_____

_____

Describe any unusual habits or behavior or strange ideas:

_____

_____

Describe what the child likes to do for fun:

_____

_____

Describe how the child reacts to pain:

_____

_____

Describe any problems in sitting still or paying attention or completing an activity:

_____

_____

Describe any difficulty pronouncing words or speaking:

_____

_____

Describe any difficulties in learning or understanding at home:

_____

_____

EDUCATION

Name of School: _____ Grade: _____ Teacher: _____

Describe child's behavior at school:

_____

_____

Describe any difficulties learning at school:

_____

_____

Describe any special education programs in which child has participated:

_____

_____

List previous schools attended with dates:

_____

_____

Has child ever repeated a grade? _____ If so, when? _____

What was the problem? _____

_____

Describe any timidity, fear, or shyness: _____

_____

_____

_____

_____

Checklist of problems – check where applicable:

	In the past	Now	Never	Comments
Ear infections				
Allergies				
Unexplained Stomach Aches				
Headaches				
Nausea				
Dizziness				
Temper tantrums				
Rocking				
Thumbsucking				

Nail bighting_____

Toe walking_____

Poor handwriting_____

Learning to read_____

Learning arithmetic_____

Describe the child's present psychological pain or upset and how you came to be aware of it:

_____
_____
_____
_____

Describe child's strengths and positive qualities:

_____
_____

With what hand does the child write? _____ Eat? _____

How is the child's vision? _____

How is the child's hearing? _____

When did the child last have a physical examination? _____

_____

Physical condition at the time of examination: _____

_____

Who referred you to the Counseling Center? Name: _____

Have there been any previous psychological, psychiatric, neurological, or EEG evaluations of the child? _____

If so, please list below the names, addresses, and dates of contact. Indication your understanding of the results:

_____
_____
_____
_____

Have any other members of the household consulted a professional for psychological, emotional, psychiatric, neurological, or educational problems within the last few years? _____

If yes, explain:

_____
_____
_____
_____

Signed _____

Relation to child _____

We appreciate the trouble to which you have gone in filling out this questionnaire. Your answers help us to evaluate the problem in a more efficient manner. Please add any comments on the backs of this and any other pages.