COUNSELING AND ASSESSMENT PRACTICE OF FAIRFAX
HISTORY AND BACKGROUND QUESTIONNAIRE

CHILD or ADOLESCENT FORM

Please answer all of the questions below, even if some may not apply directly to you or your child. In order to help us more fully learn about your child, please provide us with photocopies of your child's recent school report cards, standardized test score results, and any educational, medical, or psychological reports. Please PRINT so we can read your handwriting.

IDENTIFYING INFORMATION

CLIENT'S NAME: _____ TODAY'S DATE:_____/_____/_____

GENDER (circle): Male Female CHILD'S AGE: _____years GRADE: _____ BIRTH DATE: _____/_____/_____
Month Day Year

RACE/ETHNICITY (circle any that apply)**:**

American Indian/Alaskan Native Asian Black/African American Hispanic/Latino Hawaiian/Pacific Islander White Other

LEGAL GUARDIAN(S): _____ RELATION TO CHILD: _____

If divorced, please provide a copy of the custody agreement.

CHILD'S PRIMARY LANGUAGE: _____

LANGUAGE(S) SPOKEN AT HOME:_____

HOME ADDRESS: _____ DAYTIME PHONE_____

_____ CELL/OTHER PHONE_____

EMAIL Address: _____

CHILD'S SCHOOL: _____ COUNTY: _____

RECENT ABILITY or ACHIEVEMENT TESTS TAKEN: _____

Person filling out this form (circle): Mother Father Stepmother Stepfather Other _____

REASON FOR REFERRAL

Describe the reason(s) you have brought your child to our offices. _____

_____

_____

How long has this reason been noticeable to you? _____ How old was your child when it was first noticed? _____

What seems to help it? _____

What seems to make it worse? _____

Have any other family members shown similar characteristics? Yes No Whom? _____

Has the child received a previous evaluation or intervention for similar reasons? Yes No

If *Yes*, when and with whom?_____

Is the child on any medication at this time? Yes No If yes, please write name(s):_____

How did you hear about us? _____

DEVELOPMENTAL HISTORY

Was your child adopted? Yes No

PREGNANCY:

Was the pregnancy planned? Yes No Duration of Pregnancy (weeks or months): _____

During the pregnancy, did the mother:

___ suffer from illness or disease
___ undergo surgery
___ take medication
___ undergo X-ray studies
___ smoke tobacco
___ consume alcohol
___ use drugs

Complications of this pregnancy included:

___ excessive vomiting
___ excessive staining or blood loss
___ threatened miscarriage
___ infection(s)
___ toxemia
___ diabetes
___ maternal anemia
___ high blood pressure
___ nutrition/weight problems
___ amniocentesis or CVS
___ ultrasound
___ loss of consciousness

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

DELIVERY AND POST-DELIVERY:

Duration of Labor: _____hours Birth Weight: _____lbs. _____ozs. Length: _____

Type of Labor (circle): Spontaneous Induced Forceps (circle): Not used High Mid Low

Type of Delivery (circle): Normal Breech Caesarean Anesthesia at delivery: _____

Delivery Complications:

___ None
___ Cord around neck
___ Cord presented first
___ Hemorrhage
___ Delay or distress in respiration
___ Meconium aspiration
___ Delay in cry
___ Multiple births
___ Multiple births
___ Injury to infant
Other _____
_____

Total days baby was in hospital after delivery: _____ Total days in incubator: _____

Medications administered to baby:_____ APGAR Ratings (if known): _____ at 5 minutes after birth

Neonatal Complications:

___ None
___ Addiction
___ Anemia
___ Birth defects
___ Breathing problems
___ Cyanosis (turned blue)
___ Diarrhea
___ Feeding problems
___ Infection
___ Jaundice (yellow)
Other _____
_____

DEVELOPMENTAL MILESTONES:

The following is a list of infant/preschool/school-age behaviors. For each behavior you can remember, please indicate the age in months (*m*) or years (*y*) at which your child first demonstrated it. If you are not certain of the age but have some idea, write the age followed by a question mark.

Age	Behaviors	Age	Behaviors	Age	Behaviors
_____	Rolled from stomach to back	_____	Babbled	_____	Smiles spontaneously
_____	Sat without support	_____	Spoke first word	_____	Reaches for familiar people
_____	Crawls forward	_____	Put several words together	_____	Upset when separated from mother
_____	Walked holding someone's hand	_____	Can show major body parts	_____	Aware of differences between sexes
_____	Walked without support	_____	Can give first and last names	_____	Separates easily from mother
_____	Handles spoon well	_____	Can recognize letters	_____	Understands taking turns
_____	Rides tricycle	_____	Sight read first word	_____	Goes to the toilet alone
_____	Uses scissors to cut out pictures	_____	Sounded out new words	_____	Plays with several children
_____	Rides bicycle without training wheels	_____	Wrote first word	_____	Dressed and undressed self

Compared with other children, your child's early development was (circle): Normal Delayed Advanced

Describe any early indications of your child's problems. _____

EDUCATIONAL HISTORY

EDUCATIONAL BACKGROUND:

Did your child attend preschool and/or kindergarten? Yes No At what ages? _____

Did teachers report any concerns about his or her early school performance or behavior? _____

_____

Did your child show unusual abilities in any academic area (e.g., reading, math) at an early age? Yes No If *Yes*, explain _____

_____

Has your child attended any school with a nontraditional approach to teaching and learning? Yes No If *Yes*, explain _____

Has your child changed schools for reasons other than normal academic progression? Yes No If *Yes*, when and for what reason?

_____

Has your child skipped or repeated a grade in school? Yes No If *Yes*, explain _____

RECENT SCHOOL PERFORMANCE:

Please write the grades (and subjects) on your child's most recent report card, from highest to lowest. _____

_____

What activities or subjects at school does your child most enjoy? _____

_____

What activities or subjects at school does your child least enjoy? _____

_____

Has your child's school performance in (or attitude toward) school changed in the last two years? Yes No If *Yes*, explain _____

_____

Does your child have any special needs or accommodations at school? Yes No If *Yes*, explain _____

Does your child receive any special services at school? Yes No If *Yes*, explain _____

Current Educational Problems include:

___difficulty with reading
___difficulty with arithmetic
___difficulty with spelling
___difficulty with writing
___difficulty remembering
___difficulty with being organized
___does not respect rights of others
___fights with classmates
___truancy or avoidance of school
___does not like school
___does not complete homework
___does not sit in seat
___frequently inattentive or distracted
___disrupts classroom
___does better 1 to 1 than in groups
___doe snot work well independently

When did school problems being (or first come to your notice): _____

Describe any other classroom behavioral problem(s): _____

_____

Do you have any concerns about the quality of your child's school or teachers? _____

HOME AND SOCIAL INFORMATION

Mother: _____ Age:____ Education:_____ Occupation: _____

Father: _____ Age:____ Education:_____ Occupation: _____

Stepparent: _____ Age:____ Education:_____ Occupation: _____

Stepparent: _____ Age:____ Education:_____ Occupation: _____

What adults are living in the home with the child? _____

If married, how long have parents been married: _____

If divorced, how long have parents been divorced: _____

If parents are separated or divorced, who has legal custody of the child? _____ How old was child when the separation occurred? _____

Has either parent been married before or since? Mother:_____ Father:_____

If parents are divorced or separated, how often does each parent see your child?
Father: ___Weekly or more often ___Once or twice a month ___Several times a year ___Rarely
Mother: ___Weekly or more often ___Once or twice a month ___Several times a year ___Rarely

List all people living in household: - - - - - - - - - - - - Any history of problems in these areas? - - - - - - - - - - - -
Name Relationship to Child Age School/Learning Behavior Nervous or Mental

_____

_____

_____

_____

_____

_____

Are there any other people who have a significant role on how this child is raised? _____

Does either parent's job require him/her to be away from home long hours or extended periods? _____

About how many close friends does your child have? ___None ___One ___Two or three ___Four or more

About how many times a week does your child do things with friends outside of regular school hours? _____

Does your child participate in any extracurricular activities or social organizations? Yes No If *Yes*, please list _____

_____

Beyond family, what is the age group of the people that your child prefers to be around? ___Younger ___Same-Age ___Older ___Adults

How well does your child relate to other children at school? _____

How does your child adapt socially to … One-on-one situations? _____

Small group situations? _____

Large group situations? _____

Describe any major stresses that might be affecting your child now (e.g., death, divorce, trauma): _____

What disciplinary techniques do you usually use when you child behaves inappropriately? Place a check next to each technique that you usually use. There is also space for writing in any other disciplinary techniques that you use.

Disciplinary Techniques:

___Ignore problem behavior
___Scold child
___Spank child
___Threaten child
___Reason with child
___Redirect child's interest
___Other techniques (please describe_____)
___Tell child to sit in chair
___Send child to his or her room
___Take away some activity
___Take away food
___Don't use any techniques
___Punish child another way (please describe_____)

What are your child's favorite activities? 1._____ 2._____ 3._____

CHILD'S MEDICAL HISTORY

Has your child been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit Hyperactivity Disorder (ADHD), Learning Disorder (LD), or Anxiety and Mood Disorders? Yes No If *Yes*, please specify:

_____

VISION: Date of most recent vision exam: _____

Does your child have any vision problems? Yes No If *Yes*, describe:_____

If *Yes*, is his or her vision corrected with (circle one): Eyeglasses Contact lenses

HEARING: Date of most recent hearing exam: _____

Does your child have any hearing problems? Yes No If *Yes*, please describe and note if his or her hearing been treated:_____

_____

Has your child ever had ear infections? Yes No If *Yes*, what was his or her age at the time of the first infection? _____

Total number of infections: _____ Average duration of infections? _____ Number of infections before age 3: _____

Names of antibiotics used: _____ Was an examination conducted by an audiologist? Yes No

Were tubes inserted in the child's ears? Yes No If *Yes*, at what age(s) and for how long? _____

Check any of the following problems that were present: ___Comprehension problems ___Covered ears with hands when noisy
___Irritability ___Language delay ___Loud television or radio ___Pain complaints ___Speech problems ___Talks loudly

MOTOR COORDINATION:

Which hand does your child prefer for writing or drawing? ___Right hand ___Left hand ___Either ___Don't know

Place a check next to any motor behavior on which your child seems awkward or uncoordinated: ___Writing ___Using eraser ___Using scissors ___Using eating utensils ___Throwing ___Catching ___Walking ___Running

SENSORY STIMULATION:

Place a check next to any areas of unusual sensitivity displayed by your child: ___Bright light ___Loud sound ___Being touched

Is your child allergic to any medicines, foods, or other substances? Yes No If *Yes*, please specify _____

CHILDHOOD ILLNESSES:

Place a check next to any illness or condition that your child has had. Write the approximate date (or child's age at the time) next to illnesses within the last two years.

Illness or Condition	Illness or Condition	Illness or Condition
___ Anemia	___ Epilepsy or seizures	___ Loss of consciousness
___ Arthritis (juvenile)	___ Fainting	___ Malnutrition
___ Bleeding problems	___ Fatigue (if chronic and severe)	___ Measles
___ Bone or joint disease	___ Hay fever	___ German measles
___ Broken bones	___ Head injury	___ Meningitis
___ Cancer	___ Headaches (frequent or severe)	___ Mumps
___ Chicken pox	___ Heart disease	___ Paralysis
___ Diabetes	___ Hepatitis	___ Rheumatic fever
___ Diphtheria	___ High blood pressure (hypertension)	___ Scarlet fever
___ Eczema or hives	___ High fever (greater than 104 degrees)	___ Tuberculosis
___ Encephalitis	___ Jaundice	___ Whooping cough

MEDICAL TREATMENT:

Pediatrician's name: _____

Date of most recent medical exam: _____

If your child has ever undergone an operation or hospitalization, please list the problem below (usually an illness), the child's age, and the medical procedures that were implemented during the hospitalization.

Problem (or illness)	Age	Medical Procedures during the Hospitalization
_____	____	_____
_____	____	_____

If your child has ever been treated with prescription medication other than for colds and minor infections, please list them below:

Medication	Age	Reason Prescribed
_____	____	_____
_____	____	_____

FAMILY MEDICAL HISTORY

Have any other family members shown similar problems or challenges? Yes No If *Yes*, who? _____

Place a check next to any illness or condition that any member of the family has had. When you check an item, please note the FAMILY member's relationship to the child.

	Condition	Relationship to child			Relationship to child
____	ADHD or Hyperactivity	_____	____	High Blood Pressure	_____
____	Anxiety or Worry Problem	_____	____	Huntington's Chorea	_____
____	Depression	_____	____	Kidney Disease	_____
____	Learning problems	_____	____	Mental Retardation	_____
____	Manic-Depressive Disorder	_____	____	Migraine Headaches	_____
____	Reading Problem	_____	____	Muscular Dystrophy	_____
____	Speech or Language Problem	_____	____	Multiple Sclerosis	_____
____	Sexual/physical abuse	_____	____	Nervous Breakdown or Problems	_____
____	Hemophilia	_____	____	Parkinson's Disease	_____
____	Alcoholism	_____	____	Physical Handicap or Disability	_____
____	Alzheimer's Disease	_____	____	Seizures or Epilepsy	_____
____	Birth Defect	_____	____	Sickle Cell Anemia	_____
____	Cancer	_____	____	Stroke	_____
____	Cerebral Palsy	_____	____	Suicide attempt	_____
____	Cystic Fibrosis	_____	____	Tay-Sachs Disease	_____
____	Diabetes	_____	____	Tourette's Syndrome or Tic Disorder	_____
____	Drug Addiction or Dependency	_____	____	Tuberculosis	_____
____	Heart Disease or Heart Attack	_____	____	Other_____	_____

Is there any other information that you think may help us in understanding and working with your child? _____

_____

Is any legal action currently underway in this family? Yes No If *Yes,* explain_____