

3. _____
4. _____
5. _____
6. _____

Please provide name and relationship to the child/teen/family of anyone else living in the home currently.

Family History of Medical and/or Emotional Difficulties

Describe any major medical problems in family members: _____

History of the Current Problem

What is the problem that brings your child/teen to the Psychology Division?

At what age was the child/teen's problem first noted? _____

Please describe any illness or injury that may have been associated with the problem:

Has your child/teen ever had treatment for this problem? _____
 Where? _____ When? _____

Has your child/teen had psychological treatment for any other problem? ____ Yes ____ No
 If yes, where? _____ When? _____

Does anyone else in the family have a similar problem? _____

Birth, Developmental and Medical History of the Child/Teen

Did mother use any of the following during pregnancy?

Tobacco _____ Yes _____ No
Alcohol _____ Yes _____ No
Drugs _____ Yes _____ No

Describe any difficulties during pregnancy: _____

Length of pregnancy _____ Birthweight _____

Describe any difficulties during delivery: _____

Were there any medical problems noted at or immediately following birth? _____

Developmental History of Child/Teen

Please state the age at which your child/teen did the following. If you do not remember the exact age, give the approximate age. (Check baby books, if possible.)

MOTOR

LANGUAGE

Sat alone _____
Stood alone _____
Walked alone _____

Started using single words (other than
"mama" and "dada") _____
Used 3-word sentences _____

Please indicate any difficulties your child/teen has had with the following:

Toileting _____ In the past _____ Currently _____ Never
Eating _____ In the past _____ Currently _____ Never
Sleeping _____ In the past _____ Currently _____ Never

Medical History of Child/teen

(If you need more room, feel free to add your own page)

Describe any serious accident, illness or injury which your child/teen has had and at what age:

Please list any operations your child/teen has had and when _____

List any medications your child/teen is presently receiving (name of drug(s) and dosage times when given) _____

Child/Teen's current height _____ weight _____

Educational History

Attended pre-school? _____ Yes _____ No

Attended kindergarten? _____ Yes _____ No

In special classes? _____ Yes _____ No

Type of classes? _____ When? _____

Repeated grade(s)? _____ Yes _____ No

Grade(s) held? _____

Ever had psychological testing at school? _____ Yes _____ No

(If so, please attach a copy of the report or have a copy sent to us.)

Ever been suspended/expelled? _____ Yes _____ No

If yes, what grade(s)? _____ Why? _____

School now attending: _____ Grade _____

School address: _____

School district: _____

Name of classroom teacher: _____

Telephone number of school: _____

Strengths and Assets of the Child/Teen and Family

What are your child/teen's strengths? _____

What are your family's strengths? _____

Please tell us anything else you think will be of help in our understanding your child/teen. Include any questions that you would like us to answer. Feel free to add your own page if you need more room.

Thank you for taking the time to complete this questionnaire!

Signature of person filling out form: _____

Relationship to the child/teen: _____ Date _____

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