

Aspiring Families, Center for the Child and Family
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CHILD HISTORY QUESTIONNAIRE

Today's Date: _____

Parent Information:

Name _____

Home Address _____

City/State/Zip _____

Home Phone _____

Work Phone _____

Drivers License # _____

Date of Birth _____

Social Security Number _____

Employer _____

Work Address _____

City/State/Zip _____

Work Phone _____

Name of Spouse/Partner _____

Names of Legal/Custodial Parent/s _____

Child Information

Name _____

Date of Birth ____/____/____

Address _____
Street *Apt.*

City *State* *Zip*

Mother's Name _____ Age ____ Occupation _____

Father's Name _____ Age ____ Occupation _____

Home Telephone _____ Work/Day Phone _____

Child's Legal Guardian(s) _____

In case of an emergency, please contact:

Name: _____ Relationship to Child: _____

Tel #: _____

Referred by: _____ Relation to child _____

Referrer's Address _____

If referred by self, how did you obtain Dr. Maker's name and number? _____

Reason for Referral _____

Primary Care Physician's Name _____

Address _____

Date of Last Physical _____

Please list any current medical concerns _____

Please list any medications child is taking, including dosages and frequency _____

Please list members of child's immediate family and other members of household _____

Parental Status

If partnered, for how long: _____ If married, on what date: _____

If separated or divorced, please give date(s) and on the back of this page explain the circumstances, custody & visitation schedule (if any) and communication status between parents. Additionally, please attach a copy of the custody order.

If a parent is deceased, please give the date and explain the circumstances:

Developmental History

If adopted, please give any relevant information about biological parent history:

Briefly describe your child:

(If adopted, please answer to the best of your knowledge).

Were there any illnesses/complications during pregnancy with this child?

Total number of pregnancies: _____

Were there any miscarriages: _____ Please explain circumstance(s):

Pregnancy was (circle one)

Full Term

Premature

Late

If premature or late, number of weeks _____

Labor was (circle one) Less than 2 hours More than 24 hours 2 to 24 hours

Delivery was (circle one)
 Normal Induced Breech Cesarean Section

Birth Weight _____

During pregnancy, did any of the following occur? If yes, please add additional detail, including when in pregnancy, frequency, names of medications, etc.

Bleeding	Yes	No	_____
High Blood Pressure	Yes	No	_____
Frequent Nausea or Vomiting	Yes	No	_____
Serious Illness or Injury	Yes	No	_____
Gestational Diabetes	Yes	No	_____
Use Alcohol	Yes	No	_____
Smoke Cigarettes	Yes	No	_____
Take Prescription Medications	Yes	No	_____
Use Drugs	Yes	No	_____

During delivery, did any of the following occur? If so, please specify

Fetal cardiopulmonary distress	Yes	No	_____
Cord wrapped around neck	Yes	No	_____
Need for oxygen	Yes	No	_____
Had difficulty breathing	Yes	No	_____
Infection	Yes	No	_____
Injury	Yes	No	_____
Early distress or birth defect	Yes	No	_____
Did baby leave hospital with mother? Yes	Yes	No	_____

Is there anything else of note regarding pregnancy or delivery? _____

Early Development

During the first year, was your child:

Please describe:

Alert	Yes	No	_____
Difficult to feed	Yes	No	_____
Difficult to get to sleep	Yes	No	_____
Difficult to put on a schedule	Yes	No	_____
Colicky	Yes	No	_____
Easy to soothe	Yes	No	_____
Cheerful	Yes	No	_____
Affectionate	Yes	No	_____
Sociable	Yes	No	_____
Active	Yes	No	_____

Was there anything else notable about your child in the first years? _____

When did your child reach the following milestones:

Smiling	Early	Average	Late	_____
Sitting	Early	Average	Late	_____
Crawling	Early	Average	Late	_____
Walking	Early	Average	Late	_____
First words	Early	Average	Late	_____
First sentences	Early	Average	Late	_____
Toilet trained	Early	Average	Late	_____
Ride a bicycle	Early	Average	Late	_____
Drawing	Early	Average	Late	_____

Were there any other early milestones of note, either early or late? _____

Medical History

Is child in generally good health? _____ If no, please describe _____

Does your child have any current medical or genetic condition? If so, please describe

Does your child have, or has your child ever had, any of the following? If so, please specify.

Vision problems	Never	Past	Current	_____
Hearing problems	Never	Past	Current	_____
Frequent ear infections	Never	Past	Current	_____
Head injury	Never	Past	Current	_____
High fevers	Never	Past	Current	_____
Broken bones	Never	Past	Current	_____
Lead Poisoning	Never	Past	Current	_____
Seizures	Never	Past	Current	_____
Allergies	Never	Past	Current	_____
Asthma	Never	Past	Current	_____
Frequent headaches	Never	Past	Current	_____
Hospitalizations	Never	Past	Current	_____
Frequent falls or clumsiness	Never	Past	Current	_____
Frequent bruising	Never	Past	Current	_____
Heart or breathing difficulty	Never	Past	Current	_____
Surgery	Never	Past	Current	_____
Other serious illness or injury	Never	Past	Current	_____

Is your child currently under the care of a physician other than a pediatrician?

Has your child ever been referred to a medical specialist? If so, what specialty and why? _____

Please note any other health concerns, past or current. _____

Has your child ever had strong reactions to any of the following?

Tags on clothes, or seams on socks	Yes	No	_____
New clothing	Yes	No	_____
Tight clothing	Yes	No	_____
Hugging	Yes	No	_____
Touch	Yes	No	_____
Noises or sounds	Yes	No	_____
Smells	Yes	No	_____
Tastes or food textures	Yes	No	_____
Bright lights	Yes	No	_____

How well does your child manage transitions from one activity to another? _____

How does your child react to changes in schedule or new situations? _____

Do you have any concerns or comments about your child's social interactions with peers? _____

Family History

Does anyone in the immediate or extended family have any of the following? If so, please explain:

Attention problems	Parent	Sibling	Extended Family	_____
Learning problems	Parent	Sibling	Extended Family	_____
Difficulty reading	Parent	Sibling	Extended Family	_____
Difficulty with math	Parent	Sibling	Extended Family	_____
Difficulty writing	Parent	Sibling	Extended Family	_____
Seizure Disorder	Parent	Sibling	Extended Family	_____
Depression	Parent	Sibling	Extended Family	_____
Anxiety	Parent	Sibling	Extended Family	_____
Bipolar Disorder	Parent	Sibling	Extended Family	_____
Obsessive Compulsive Disorder	Parent	Sibling	Extended Family	_____
Other psychiatric disorder	Parent	Sibling	Extended Family	_____

School History

Name of school _____ Grade _____

Address of School _____

Telephone Number _____

Name of Teacher or Contact _____

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

Reason for repeating grade _____

Does your child receive any special help in school? _____ Is there an IEP? _____ 504? _____

If child receives help, what kind? _____

Has child ever had any psychological, educational or developmental evaluation in the past? _____

If so, where was most recent testing? _____

Please indicate whether your child:

Easily attends school Yes No _____

Becomes anxious or sick before school Yes No _____

Refuses to go to school Yes No _____

Frequently visits nurse or counselor Yes No _____

Has difficulty riding a school bus Yes No _____

Has difficulty with a teacher Yes No _____

Accuses peers of bullying Yes No _____

Has been the target of a bully Yes No _____

Fights with peers Yes No _____

Is disrespectful to teachers Yes No _____

Accuses teachers of picking on them Yes No _____

Has difficulty reading Yes No _____

Has difficulty with math Yes No _____

Has speech or language difficulties Yes No _____

Has difficulty writing Yes No _____

Has difficulty with fine motor tasks Yes No _____

Has difficulty with attention Yes No _____

Has difficulty remaining in a seat Yes No _____

Has difficulty with homework Yes No _____

Has difficulty with organization Yes No _____

Behavioral and Emotional Functioning.

Does child currently have any behavior problems at home? If so, please explain:

Does child currently have any behavior problems at school? If so, please explain _____

Does child have any emotional concerns, including depression or anxiety? If so, please explain

Is child currently in psychotherapy or counseling? If so, please list issues currently being addressed in therapy _____

Therapist's Name and Address _____

If child is under the care of a psychiatrist, please list psychiatrist's name and address:

Please list any life changes or stressors that your child has experienced. These may include moving to a new home, changing schools, physical or emotional abuse, death of a relative or other traumatic experiences. Please indicate your child's age for each event. _____

Are there any other emotional or behavioral concerns you have? _____

Please indicate whether any of the following apply to your child:

Generally positive mood	No	Yes	Past	Current	_____
Easygoing or easy to get along with	No	Yes	Past	Current	_____
Social anxiety	No	Yes	Past	Current	_____
Shyness	No	Yes	Past	Current	_____
Difficulty making/keeping friends	No	Yes	Past	Current	_____
Interacts easily with peers	No	Yes	Past	Current	_____
Has difficulty reading social cues	No	Yes	Past	Current	_____
Frequently irritable	No	Yes	Past	Current	_____
Sleep difficulties	No	Yes	Past	Current	_____
Poor appetite	No	Yes	Past	Current	_____
Overeats	No	Yes	Past	Current	_____
Anorexia	No	Yes	Past	Current	_____
Binge eating and/or purging	No	Yes	Past	Current	_____
Expresses a wish to die	No	Yes	Past	Current	_____
Self-injurious behaviors	No	Yes	Past	Current	_____
Fears or phobias	No	Yes	Past	Current	_____
Repeats one action/behavior	No	Yes	Past	Current	_____
Obsessive interest in one subject	No	Yes	Past	Current	_____
Cries easily	No	Yes	Past	Current	_____
Mood swings	No	Yes	Past	Current	_____
Easily angered	No	Yes	Past	Current	_____
Bedwetting	No	Yes	Past	Current	_____
Toileting problems	No	Yes	Past	Current	_____
Experienced physical abuse	No	Yes	Past	Current	_____
Experienced sexual abuse	No	Yes	Past	Current	_____
Witnessed domestic violence	No	Yes	Past	Current	_____
Experienced emotional abuse	No	Yes	Past	Current	_____
Risk taking behaviors	No	Yes	Past	Current	_____
Suicide attempt	No	Yes	Past	Current	_____
Plays with fire	No	Yes	Past	Current	_____
Drug or alcohol use	No	Yes	Past	Current	_____
Problems with law enforcement	No	Yes	Past	Current	_____
Steals	No	Yes	Past	Current	_____
Lies	No	Yes	Past	Current	_____
Bullies others	No	Yes	Past	Current	_____
Harms or is cruel to animals	No	Yes	Past	Current	_____

Psychological/Educational Assessment (Please complete if this applies to your child):

Please describe the concerns you have for yourself or your child. Also, please add any additional information that you think would be useful in this assessment:

What question(s) do you hope will be answered with this assessment?

Your name _____ Relation to child _____ Date _____

Signature _____