BACKGROUND INFORMATION - FOR YOUTH

Instructions: *Parents or legal guardians should complete the following questionnaire. All information will be kept confidential. If you do not wish to respond to an item on the questionnaire, just write "no response" in the space provided.*

First Name	**Middle Name**	**Last Name**
Date of Birth	**Age**	**Grade**
Form Completed By	**Relationship**	**Today's Date**

SECTION 1 - FAMILY INFORMATION

Address (Number, Street, Apartment, City, State, Zip Code)

Phone Number(s) **E-mail Address**

Mother's Name **Father's Name**

Marital status of child's parents:
[ ] Married
[ ] Unmarried
[ ] Separated
[ ] Divorced (for how long) ________________________
[ ] Remarried (for how long) ________________________

Names of siblings residing in the home:

Name ______________________________ Age__________
Name ______________________________ Age__________
Name ______________________________ Age__________
Name ______________________________ Age__________
Name ______________________________ Age__________

SECTION 2 – PREGNANCY/DELIVERY

General health during pregnancy:
[ ] Excellent [ ] Good [ ] Poor (please explain)______________________________

During your pregnancy, indicate if you often used:
[ ] Cigarettes [ ] Alcohol [ ] Other drugs [ ] None of the above

Pregnancy was:
[ ] Without complications [ ] With complications (please explain)______________________________

Delivery was:
[ ] Without complications [ ] Induced [ ] C-Section [ ] Other (please explain)______________

Infant's birth weight was: __________ lbs ___________oz **Apgar scores:**______________________

Infant's health at birth was:
[ ] Excellent [ ] Good [ ] Poor (please explain)______________________________

SECTION 3 – CHILD'S DEVELOPMENTAL HISTORY

Please place a mark [X] through the box if your child had difficulty in any of these areas during the FIRST THREE YEARS of life.

[ ] Poor eye contact
[ ] Colicky/irritable
[ ] Sleep problems
[ ] Threw tantrums
[ ] Stubborn
[ ] Didn't get along well with peers/other children
[ ] Difficulty adjusting to schedules (e.g., eating, sleeping)
[ ] Resisted changes in schedule
[ ] Resisted affection from others
[ ] Slow cognitive development
[ ] Overly fearful
[ ] Difficult to comfort
[ ] Overactive
[ ] Accident prone
[ ] Separating from mother

Overall, as a toddler, I would describe my child's temperament as (check one):

[ ] Extremely difficult [ ] Difficult [ ] Average [ ] Very easy

Indicate the age at which your child developed the following skills:

Crawling: __________
Walking: __________
First words: __________
Ability to complete simple chores independently: __________
Toilet training: __________
Riding a bike: __________
Getting dressed without help: __________
Throwing a ball: __________

SECTION 4 – CHILD'S MEDICAL HISTORY

Family Physician____ Phone # ____________________________________

Please place a mark through the box if your child has had any of the following medical conditions.

[ ] Asthma ______________________________________
[ ] Allergies ______________________________________
[ ] Bedwetting ____________________________________
[ ] Diabetes ______________________________________
[ ] Seizure disorder _______________________________
[ ] Surgeries – for what? ___________________________
[ ] Head Trauma __________________________________
[ ] Chronic ear infections _________________________________
[ ] Hearing loss ____
[ ] Vision problems _______________________________________
[ ] Poor motor coordination _________________________________
[ ] Sleep problems _______________________________________
[ ] Appetite problems (under/over eats) ______________________
[ ] Serious injuries (broken bones, stitches, etc.) ______________

Overall, I would describe my child's current level of health as being: [ ] Excellent [ ] Good [ ] Poor

My child is currently taking the following medications:

Name of medication ____ For what condition? _________________________
Name of medication ____ For what condition? _________________________
Name of medication ____ For what condition? _________________________
Name of medication ____ For what condition? _________________________
Name of medication ____ For what condition? _________________________

SECTION 5 – FAMILY HISTORY

Please check the box [X] if either of the child‘s biological parents have experienced any of the following conditions:

[ ] Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)
[ ] Learning Disabilities/Academic Underachievement
[ ] Communcation disorders/disabilities
[ ] Depression
[ ] Anxiety Disorder(s)
[ ] Obsessive-Compulsive Disorder (OCD)
[ ] Autism/Asperger’s Syndrome
[ ] Tourette’s Syndrome
[ ] Substance Abuse
[ ] Criminal Misconduct

Please check the box if any of the child’s biological siblings have experienced any of the following conditions:

[ ] Attention-Deficit/Hyperactivity Disorder (ADHD/ADD)
[ ] Learning Disabilities/Academic Underachievement
[ ] Communcation disorders/disabilities
[ ] Depression
[ ] Anxiety Disorder(s)
[ ] Obsessive-Compulsive Disorder (OCD)
[ ] Autism/Asperger’s Syndrome
[ ] Tourette’s Syndrome
[ ] Substance Abuse
[ ] Criminal Misconduct

SECTION 6 – CHILD’S EDUCATIONAL HISTORY

Please list any previous schools your child has attended.

Name of school ______________________________ City ____________________
Name of school ______________________________ City ____________________
Name of school ______________________________ City ____________________
Name of school ______________________________ City ____________________

Please check the box [X] and provide brief details if the item is true about your child. If you are unsure about an item, leave it blank.

[ ] My child has been previously evaluated for school-related problems ____________________
[ ] My child has had to repeat a grade ____________________
[ ] My child has difficulty learning academic material ____________________
[ ] My child has difficulty following school rules ____________________
[ ] My child has difficulty forming friendships at school ____________________
[ ] My child resists going to school and/or complains about disliking school ____________________
[ ] My child has received counseling at school ____________________
[ ] My child is or has been in special education (resource) ____________________
[ ] My child has (or has had) a 504 plan ____________________
[ ] My child has a medical condition that may affect his/her ability to succeed at school – please describe _______________
____

Please describe any additional information about your child’s school history that you feel might be helpful.

____
____
____
____

SECTION 7 – CURRENT BEHAVIORAL CONCERNS

Please place a mark [X] through the boxes that describe a current concern that you have about your child.

Behavior

[ ] Overactive/always on the go
[ ] Impulsive; acts without thinking about behavioral consequences
[ ] Distractible; shifts focus from one activity to another
[ ] Difficulty complying to rules and expectations
[ ] Talks too much; interrupts others
[ ] Can't play quietly
[ ] Doesn't complete tasks or chores
[ ] Disorganized; frequently loses things
[ ] Forgetful; has trouble following directions
[ ] Impatient; difficult waiting for turns

Compliance to Rules and Social Norms

[ ] Refuses to comply with adults and rules
[ ] Argues with adults
[ ] Throws tantrums
[ ] Physically aggressive toward others; gets in fights
[ ] Destroys property
[ ] Dishonest; lies, cheats, steals
[ ] Bullies/threatens others
[ ] Seems angry/vindictive

General Mood

[ ] Cries often or without apparent reason
[ ] Irritable/moody
[ ] Doesn't seem to enjoy activities that used to be fun
[ ] Can't sleep at night/sleeps too much during the day
[ ] Expresses suicidal thoughts ("I don't want to live anymore")
[ ] Loss of appetite
[ ] Excessive fatigue/loss of energy
[ ] Complains of having no friends
[ ] Complains about feeling unloved
[ ] Says he/she is depressed

Anxiety Level

[ ] Worries excessively (e.g., sickness, weather, safety, school)
[ ] Difficulty sleeping
[ ] Complains of headaches, stomachaches, nausea when not appearing sick
[ ] Loss of energy/easily fatigued
[ ] Difficulty separating from parents
[ ] Difficulty concentrating
[ ] Restless/easily agitated

Peer Relationships

[ ] Complains that "nobody likes me"
[ ] Bossy/has to have own way
[ ] Doesn't follow rules when playing games
[ ] Doesn't show concern for the welfare of others
[ ] Has difficulty sharing and cooperating with others
[ ] Sore loser
[ ] Argues and fights with peers
[ ] Teases others
[ ] Bullies others
[ ] Does not have a "best friend"

School Performance

[ ] Academic deficits; not learning as quickly as classmates
[ ] Behavior problem; disruptive/does not follow rules
[ ] Fails to complete classwork and homework
[ ] Resists going to school
[ ] Low test scores
[ ] Excessive absences/tardiness
[ ] Social problems; has few friends at school

SECTION 8 – ADDITIONAL INFORMATION

Please use the lines below to indicate your child's individual strengths and positive personality characteristics.

____
____
____
____
____
____

Please use the lines below to provide additional information about your child that may be of importance for us to know.

____
____
____
____
____
____

Thank you for providing this information. Please bring the completed questionnaire with you to your appointment.