HISTORY QUESTIONNAIRE

Date: _____

PLEASE PRINT:

Child's Name: _____
(last) (first) (middle)

Address: _____ Phone: _____

City: _____ Zip Code: _____

Date of Birth: _____ Present Age: _____

Referred by: _____

Name of School: _____ City: _____ Grade: _____

Teacher(s): _____

Please describe child's difficulties: _____

_____

_____

_____

When was this problem(s) first noticed and by whom? _____

_____

Has the child or other family members been seen by someone for these problems?

_____

By whom: _____

What findings and recommendations did they give you? _____

_____

Father's Name: _____

Birthdate: _____ Education: _____

Occupation: _____

Social Security #: _____

Name & Address of Employer:

_____

Telephone: Home: _____

Work: _____

Cell: _____

Mother's Name: _____

Birthdate: _____ Education: _____

Occupation: _____

Social Security #: _____

Name & Address of Employer:

_____

Telephone: Home: _____

Work: _____

Cell: _____

Number of years married? _____

If divorced, state date of divorce _____

Describe custody arrangements: _____

_____

_____

If there are stepparents, give following information:

Name: _____

Age: _____

Education: _____

Occupation: _____

Social Security #: _____

Place of employment: _____

Is child adopted? _____ At what age? _____ Does the child know of the adoption? _____

Other children in family (including stepchildren):

Name	Age	Grade	If not living in home, where do they live?

Name, address and telephone number of child's pediatrician: _____

_____

Date of last visit: _____

Other physicians caring for child: _____

Was this a planned pregnancy? _____

Were there any difficulties during the pregnancy and/or delivery / any toxemia? _____

_____

At birth, was the child given: Oxygen: _____ Blood Transfusions: _____

Birth weight: _____ Physical disabilities noted at birth: _____

Fetal Alcohol Syndrome exposure? _____

Prenatal drug use by mother? _____

At what age did your child crawl?_____ Sit? _____ Walk?_____

First Words _____ Sentences_____

Was child breast or bottle fed? _____ For how long? _____

Was feeding regulated by: Demand_____ Schedule_____ Combination _____

Was weaning difficult? _____

Did child use pacifier and/or suck thumb? _____

For how long? _____

Are there any eating difficulties? Describe: _____

At which age toilet trained for daytime: _____ Night? _____

Describe how this was accomplished _____

Was this difficult? _____ Is child a bed wetter? _____

How frequently? _____

Does child soil? _____ How frequently? _____ Constipation? _____

Are there any sleep problems?_____

Does child have nightmares? _____

Does child sleep in his/her own bed?_____

Does child have his/her own bedroom?_____

Has child shown curiosity about sexual and gender issues (birth, babies, differences between boys and girls, etc.) Please describe _____

_____

_____

_____

Age at onset of menstruation:_____ Any problems? _____

Is child under any medications now? _____ What? _____

Why? _____

Are there any speech problems? _____ What? _____

Are there any nervous habits? _____ What _____

Sleeping habits? _____ Rocking and/or head banging? _____

Has your child ever been hospitalized or had outpatient surgery? _____

When? _____ Physician: _____ What for? _____

How long? _____

Has your child ever had seizures or convulsions? ____ Age began _____

Frequency? _____ Date of last seizure? _____

Neurologist: _____ Date of last visit: _____

Has your child ever lost consciousness? _____ Age? _____ Reason: _____

Has your child ever had a high fever (over 103)? Reason: _____

Has your child ever had his/her vision checked? _____ Does child wear glasses? _____

Has your child ever had his/her hearing checked? _____

Does child wear a hearing aid? _____

Does your child have any physical disability or chronic illness? _____

Has your child ever injured his/her head seriously? _____Age _____

Explain the circumstances and treatment needed: _____

Has he/she ever been away from parents for any length of time (i.e., overnight camp, vacation, hospitalization, etc) _____ Reaction: _____

_____

Describe how your child gets along with mother: _____

Describe how your child gets along with father: _____

Describe how your child gets along with siblings: _____

Describe how your child gets along with friends: _____

How does your child respond to discipline? What methods are used? _____

_____

How does your child express angry feelings? _____

_____

Child care arrangements since birth:
Please indicate age of child: Day care? _____

Baby Sitter? _____

Your home or sitter's home? _____

Full-time in home _____

Preschool Name: _____

Age when attended: _____

Adjustment to preschool: _____

What are current child care arrangements? _____

How does child get along with children their age? _____

Older than him/herself? _____ Younger _____ Brothers & Sisters? _____

Does child play well by him/herself? _____

What special interests or hobbies does child have? _____

What fears does child have (i.e., dogs, dark, thunder & lightning, bugs, crowds, etc)?

_____

_____

Does child enjoy books? _____ Being read to? _____ Who reads to child? _____

What TV programs does child prefer? _____

What games does child like? _____

What are child's favorite toys? _____

Any difficulty in school achievement: Writing? _____ Reading? _____

Math? _____ Behavior? _____ Other? _____

Please check any of the following items which apply to your child:

Headaches	Nervous	Moving around
Clumsy	Athletic	Stomachaches
Bold	Generous	Easily discouraged
Temper outbursts	Enthusiastic	Selfish
Easygoing	Indifferent	Shy
Carefree	Careless	Moody
Friendly	Courteous	Lazy
Mentally slow	Average	Aggressive
Quiet	Tantrums	Bright
Very Active	Cooperative	Hyperactive

If there is anything else about your child which you feel we should know, please use the back of this page.

Name of person filling out this form and relationship to patient:

_____