SYMATREE

CHILD & ADOLESCENT BACKGROUND QUESTIONNAIRE

The following is a questionnaire on your child's development, medical history, and current functioning at home and at school. This information will help to provide a better picture of your child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can.

CHILD'S FAMILY

Child's Name: _____ Today's Date:_____
Birth date: _____ Age: _____ Grade: _____ Name of School: _____

Address: _____ City:_____ State:_____ Zip:_____
Home phone #: _____ Cell #: _____ Work #: _____

Who referred you/your child?: _____
Person filing out this form: ❍ Mother ❍ Father ❍ Stepmother ❍ Stepfather ❍ Other: _____

Biological Mother's Name: _____ Age: _____ Highest Grade Completed: _____
Degree/Diploma (if applicable): _____Occupation: _____
hours a week: _____

Biological Father's Name: _____ Age: _____ Highest Grade Completed: _____
Degree/Diploma (if applicable): _____ Occupation: _____
hours a week: _____

Marital status of biological parents: ❍ Married ❍ Separated ❍ Divorced ❍ Widowed ❍ Other:_____
If biological parents are separated or divorced: How old was this child when the separation occurred? _____
Who has legal custody of the child? (Check one) ❍ Mother ❍ Father ❍ Joint/Both ❍ Other:_____

Step-father's Name: _____ Age: _____ Occupation: _____
Step-mother's Name: _____ Age: _____ Occupation: _____

If this child is not living with either biological parent: Reason: _____
_____
❍ Adoptive parents ❍ Foster parents ❍ Other family members ❍ Group home ❍ Other: _____
Name(s) of legal guardian(s): _____

List all people currently living in your child's household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages: _____
_____
_____

Primary language spoken in the home: _____Other languages spoken in the home: _____
If your child's first language is not English, please list first language: _____
Age at which your child learned English: _____

BEHAVIOR CHECKLIST

Place a check mark (√) next to behaviors that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

Sleeping and Eating

( )Nightmares	( )Sleepwalking	( )Trouble sleeping (describe): _____
( )Eats poorly	( )Picky eater	( )Eats excessively

Social Development

( )Prefers to be alone	( )Shy or timid	( )More interested in objects than people
( ) Difficulty making friends	( )Plays or socializes with younger children	( )Teased by other children
( )Bullies other children	( )Does not seek friendships with peers	( )Not sought out for friendship by peers

( ) Does not play or socialize with other children outside of school	( ) Difficulty seeing another person's point of view
( ) Doesn't empathize with others	( ) Overly trusting of others
( )Overly familiar with people	( ) Easily taken advantage of
( )Overly attached to certain people	( ) Difficulty understanding humor

Behavior

( ) Stubborn	( ) Irritable	( ) Frequent tantrums
( ) Strikes out at others	( ) Throws things at others	( ) Destroys things
( ) Angry or resentful	( ) Oppositional	( ) Negativistic
( ) Lying	( ) Argues with adults	( ) Low frustration threshold
( ) Daredevil behavior	( ) Runs away	( ) Blames others for own mistakes
( ) Needs a lot of supervision	( ) Talks excessively	( ) Impulsive (does things without thinking)
( ) Skips school	( ) Interrupts frequently	( ) Poor sense of danger
( ) Purposely harms or injures self	( ) Dangerous to self or others	( ) Talks about hurting self
( )Not affected by negative consequences	( ) Steals	( ) Depressed
( ) Cries frequently	( ) Sucks thumb	( ) Excessively worried and anxious
( ) Alcohol abuse	( ) Drug abuse	( ) Overly attached to certain objects
( ) Not affected by praise	( ) Sexually active	( ) Overly preoccupied with details
( ) Wets self during the day	( ) Wets bed	( ) Motor/Vocal tics
( ) Poor bowel control (soils self)	( ) Overreacts to noises	( ) Overreacts to touch
( ) Fails to react to loud noise	( ) Poor sense of danger	( ) Has blank spells
( ) Excessive daydreaming/fantasy life	( ) Bites nails	( ) Picks nose
( ) Masturbation in public places	( ) Bangs head	( ) Other: _____

( ) Unusual fears, habits, repetitive behaviors, or mannerisms:_____

Motor Skills

( ) Poor fine motor coordination	( ) Poor gross motor coordination	( ) Clumsy
( ) Cannot tie shoes	( ) Cannot dress self	( ) Difficulty walking
( ) Difficulty running	( ) Cannot throw or catch	

EDUCATION PROGRAM

Name of your child's primary teacher: _____ Phone: _____

Does your child have an individual education plan (IEP) or modified learning program? ( ) Yes (date of last update_____) ( )No

If yes, are you satisfied with the IEP? ( ) Yes ( )No If not satisfied, please explain:_____

_____

Has your child ever repeated a grade? ( ) Yes ( )No If yes, what grade(s) and why? _____

Is your child's curriculum modified? ( ) Yes ( )No If yes, please describe: _____

Is your child in any special education classes? ( ) Yes ( )No If yes, please describe: _____

Is your child receiving assistance at school? ( ) Yes ( )No If yes, please describe: _____

Has your child been suspended or expelled from school? ( ) Yes ( )No If yes, please describe: _____

Has your child ever received tutoring outside of school? ( ) Yes ( )No If yes, please describe: _____

Rate your child's academic performance relative to other children of the same age. Please estimate the grade level your child is functioning at in the given area if he or she is above or below average.

	Above Average	Average	Below Average	Impaired	Grade Level
Handwriting	( )	( )	( )	( )	_____
Spelling	( )	( )	( )	( )	_____
Punctuation	( )	( )	( )	( )	_____
Vocabulary	( )	( )	( )	( )	_____
Reading speed	( )	( )	( )	( )	_____
Reading comprehension	( )	( )	( )	( )	_____
Math skills	( )	( )	( )	( )	_____

Check any problems reported from school:

( ) Difficulty sustaining attention	( ) Easily distracted	( ) Daydreaming
( ) Fidgeting / restless	( ) Frequently gets out of seat	( ) Difficulty working quietly
( ) Difficulty working independently	( ) Doesn't want to be called on	( ) Blurts out answers
( ) Teased by other children	( ) Talking back	( ) Refusing to do work
( ) Bullies other children	( ) Fighting ( ) Messy / disorganized	( ) Does not like school
( ) Truant	( ) Excessively tired or sleepy	( ) Difficulty following instructions
( ) Doesn't respect the rights of others	( ) Shifts from one activity to another	( ) Won't wait his/her turn
( ) Does better in one-to-one relationship	( ) Doesn't cooperate well in group activities	

Describe briefly other classroom or school problems if applicable: _____

COGNITIVE SKILLS

Rate your child's cognitive skills relative to other children of the same age.

	Above Average	Average	Below Average	Impaired
Speech	( )	( )	( )	( )
Speech Comprehension	( )	( )	( )	( )
Problem solving	( )	( )	( )	( )
Attention span	( )	( )	( )	( )
Memory for events	( )	( )	( )	( )
Organizational skills	( )	( )	( )	( )
Memory for facts	( )	( )	( )	( )
Learning from experience	( )	( )	( )	( )
Conceptual thinking	( )	( )	( )	( )
Overall Intelligence	( )	( )	( )	( )

Check any specific problems:

- ( ) Poor articulation/pronunciation
- ( ) Disorganized speech
- ( ) Talks like a younger child
- ( ) Easily distracted
- ( ) Frequently loses belongings
- ( ) Doesn't foresee consequences of actions
- ( ) Difficulty finding words to express self
- ( ) Talks too loudly or softly
- ( ) Forgets to do things
- ( ) Frequently forgets instructions
- ( ) Difficulty planning tasks
- ( ) Slow thinking

Describe briefly any other cognitive problems that your child may have: _____

_____

_____

Describe any special skills or abilities that your child may have: _____

_____

_____

DEVELOPMENTAL HISTORY

If your child is adopted, please fill in as much of the following information as you are aware of.

During pregnancy, did the mother of this child: Take any medication? ( ) Yes ( ) No

If yes, what kind? _____

Smoke? ( ) Yes ( ) No If yes, how many cigarettes each day? _____

Drink alcoholic beverages? ( ) Yes ( ) No If yes, what kind? _____

Approximately how much alcohol was consumed each day?_____

Use drugs? ( ) Yes ( ) No If yes, what kind? _____

How often were drugs used? _____

List any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc.): _____

_____

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____ Apgars (if known): ____ / ____

Were there any indications of fetal distress: ( ) Yes ( ) No If yes, for what reason? _____

_____

Check any that apply to the birth: ( ) Labor induced ( ) Forceps ( ) Breech ( ) Caesarean: for what reason?

_____

What was your child's birth weight? _____

Check any that apply following birth: ( ) Jaundice ( ) Breathing problems ( ) Incubator ( ) Birth defect, describe: _____

Were there any other complications? ( ) Yes ( ) No If yes, describe: _____

_____

Was there any maternal depression during the immediate post-natal period? _____ If yes, please describe: _____

_____

What was your first impression of your baby? _____

Were there any feeding problems? ( ) Yes ( ) No If yes, describe: _____

_____

Were there any sleeping problems? ( ) Yes ( ) No If yes, describe: _____

_____

Were there any growth or development problems during the first few years of life? ( ) Yes ( ) No If yes, describe:

_____

_____

_____

_____

Were any of the following present (to a significant degree) during infancy or the first few years of life?

( ) Unusually quiet or inactive	( ) Did not like to be held or cuddled	( ) Not alert
( ) Difficult to soothe	( ) Colic	( ) Excessive sleep
( ) Excessive restlessness	( ) Diminished sleep	( ) Head banging
( ) Constantly into everything	( ) Excessive number of accidents compared to other children	

Please indicate the approximate age in months or years at which your child showed the following behaviors. If you feel that you child was early or late in showing a listed behavior, please indicate by checking the appropriate box. Check never if your child has never shown the listed behavior.

	Age	Early	Late	Never
Smiled	_____	( )	( )	( )
Tied shoelaces	_____	( )	( )	( )
Rolled over	_____	( )	( )	( )
Dressed self	_____	( )	( )	( )
Sat alone	_____	( )	( )	( )
Fed self	_____	( )	( )	( )
Crawled	_____	( )	( )	( )
Bladder trained, day	_____	( )	( )	( )
Bladder trained, night	_____	( )	( )	( )
Walked	_____	( )	( )	( )
Ran	_____	( )	( )	( )
Bowel trained	_____	( )	( )	( )
Babbled	_____	( )	( )	( )
Rode tricycle	_____	( )	( )	( )
First word	_____	( )	( )	( )
Rode bicycle	_____	( )	( )	( )
Sentences	_____	( )	( )	( )

MEDICAL HISTORY

Name of pediatrician: _____ Pediatrician phone #: _____

Approx date of last exam: _____

Place a check next to any illness or condition that your child has had.

( ) Measles	( ) Ear infection	( ) German measles	( ) Dizziness
( ) Mumps	( ) Severe headaches	( ) Chicken pox	( ) Rheumatic fever
( ) Whooping cough	( ) Tuberculosis	( ) Diphtheria	( ) Bone or joint disease
( ) Scarlet fever	( ) Sexually transmitted disease	( ) Meningitis	( ) Anemia
( ) Pneumonia	( ) Jaundice/hepatitis	( ) Encephalitis	( ) Diabetes
( ) High fever	( ) Cancer	( ) Seizures	( ) High blood pressure
( ) Allergy	( ) Heart disease	( ) Hay fever	( ) Asthma
( ) Injuries to head	( ) Bleeding problems	( ) Broken bones	( ) Eczema or hives
( ) Hospitalizations	( ) Suicide attempt	( ) Operations	( ) Alcohol abuse
( ) Drug abuse	( ) Visual problems	( ) Physical abuse	( ) Fainting spells
( ) Sexual abuse	( ) Loss of consciousness	( ) Paralysis	( ) Poisoning
( ) Stomach pumped	( ) Other: _____		

CURRENT MEDICATIONS
List all medications that your child is currently taking:

Medication	Reason Taken	Dosage (If known)	Start Date

FAMILY MEDICAL HISTORY
Place a check next to any illness or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had. Please note the family member's relationship to the child.

- ( ) Seizures or Epilepsy _____
- ( ) Attention deficit _____
- ( ) Hyperactivity _____
- ( ) Learning disabilities _____
- ( ) Mental retardation _____
- ( ) Childhood behavior problems _____
- ( ) Neurological illness or disease _____
- ( ) Mental illness _____
- ( ) Depression or anxiety _____
- ( ) Tics or Tourette's syndrome _____
- ( ) Alcohol or drug abuse _____
- ( ) Suicide attempt _____

List had any previous assessments that your child has had:

	Dates of Testing	Name of Examiner
Psychiatric: Y / N		
Psychological: Y/ N		
Neuropsychological: Y / N		
Educational: Y / N		
Speech Pathology: Y / N		
Other:		

List any form of psychological/psychiatric treatment that your child has had (e.g., psychotherapy, family therapy, inpatient or residential treatment):

Type of Treatment	Dates	Name of Therapist

Have there been any recent stressors that you think may be contributing to your child's difficulties (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses)? _____
_____
_____

OTHER INFORMATION
What are your child's favorite activities: _____
_____
List any special interests that your child has: _____
_____
List any sports your child plays: _____
What are your child's assets or strengths? _____
_____
Has your child ever been in trouble with the law? ( ) Yes ( ) No If yes, please describe: _____
_____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use.

- ◯ Ignore problem behavior
- ◯ Scold child
- ◯ Take away some activity or food
- ◯ Threaten child
- ◯ Reason with child
- ◯ Redirect child's interest
- ◯ Don't use any technique
- ◯ Tell child to sit on chair
- ◯ Send child to his/her room
- ◯ Spank child

Which disciplinary techniques are usually effective, and with what types of problem(s)? ______________________________

____

Which disciplinary techniques are usually ineffective, and with what types of problems? ______________________________

____

On average, what percentage of the time does your child comply with requests or commands? ______________________

What have you found to be the most satisfactory ways of helping your child? ______________________________

____

What are your child's assets or strengths? ______________________________

____

Is there any other information that you think that may help me in assessing your child? ______________________________

____

Signature of person completing this form: ______________________________ **Date**:________________

Thank you for filling out this questionnaire.