

**CHILD BACKGROUND QUESTIONNAIRE
FAMILY DATA**

Child's name: _____ Today's date: _____

Birth date: _____ Age: _____ Sex (circle one): Male Female

Home address: _____ City: _____ Zip: _____

School: _____ Grade: _____

Pediatrician/Physician: _____ Phone # of Pediatrician/Physician: _____

Person filling out this form (circle one): Mother Father Stepmother Stepfather

Other (please explain) _____

If necessary, I give Dr. McCaskill permission to call me at the following numbers:

Home Phone# _____	OK to leave a message:	Yes	No
Father Work Phone # _____	OK to leave a message:	Yes	No
Mother Work Phone # _____	OK to leave a message:	Yes	No
Father Cell Phone # _____	OK to leave a message:	Yes	No
Mother Cell Phone # _____	OK to leave a message:	Yes	No
Other # _____	OK to leave a message:	Yes	No

Name of person responsible for the bill: _____ SS# _____

Mother's name: _____ Age: _____ Education: _____ Occupation: _____

Father's name: _____ Age: _____ Education: _____ Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____ Occupation: _____

Marital status of parents: _____ If parents are separated/.divorced, how old was child at time of separation? _____

List all people living in 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: _____

PRESENTING PROBLEM

Briefly describe your child's current difficulties: _____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Has the child received evaluation or treatment for the current problem or similar problems? Yes _____ No _____

If yes, when and with whom? _____

Is the child on any medication at this time? Yes _____ No _____

If yes, please note kind of medication: _____

Who referred you to my office? _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

Check

_____ Has difficulty with speech

_____ Has difficulty with hearing

_____ Has difficulty with language

_____ Has difficulty with vision

_____ Has difficulty with coordination

_____ Prefers to be alone

_____ Does not get along well with other children

_____ Is aggressive

_____ Is shy or timid

_____ Is more interested in things (objects) than in people

_____ Engages in behavior that could be dangerous to self
(describe) _____

Check

_____ Has frequent tantrums

_____ Has frequent nightmares

_____ Has trouble sleeping (describe) _____

_____ Has blank staring spells

_____ Rocks back and forth

_____ Bangs head

_____ Holds breath

_____ Eats poorly

_____ Is stubborn

_____ Has poor bowel control (soils self)

_____ Is much too active

Place a check next to any behavior or problem that your child currently exhibits.

Check

_____ Has special fears, habits, or mannerisms
(describe) _____

_____ Show daredevil behavior

_____ Gives up easily

_____ Wets bed

_____ Bites nails

Check

_____ Is impulsive

_____ Sucks thumb

_____ Is slow to learn

_____ Other (describe) _____

EDUCATIONAL HISTORY

Place a check next to any educational problem that your child currently exhibits.

Check

_____ Has difficulty with reading

_____ Has difficulty with arithmetic

_____ Has difficulty with spelling

_____ Has difficulty with writing

Check

_____ Has difficulty with other subjects (please list) _____

_____ Does not like school

Is your child in a special education class? Yes _____ No _____

If yes, what type of class? _____

Has your child been held back in a grade? Yes _____ No _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____

If yes, please describe: _____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes _____ No _____ If yes, what kind? _____

During pregnancy, did mother smoke? Yes _____ No _____ If yes, how many cigarettes each day? _____

During pregnancy, did mother drink alcoholic beverages? Yes _____ No _____ If yes, what did she drink? _____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? Yes _____ No _____ If yes, what kind? _____

Were forceps used during delivery? Yes _____ No _____

Was a Cesarean section performed? Yes _____ No _____. If yes, for what reason? _____

Was the child premature? Yes _____ No _____ If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes _____ No _____ If yes, please describe: _____

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

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

As an infant, was the child quiet? Yes _____ No _____

As an infant, did the child like to be held? Yes _____ No _____

As an infant, was the child alert? Yes _____ No _____

Were there any special problems in the growth and development of the child during the first few years? Yes _____ No _____

If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to parent	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked alone	_____	Fed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		

CHILD'S MEDICAL HISTORY

Current Pediatrician/Physician: _____
Address _____ Phone # _____

Past Pediatrician/Physician: _____
Address _____ Phone # _____

Past Pediatrician/Physician: _____
Address _____ Phone # _____

Allergies: _____

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date (or age) of the illness.

Check	Illness or condition	Date(s) or age (s)	Check	Illness or condition	Date(s) or Age(s)
_____	Measles	_____	_____	Dizziness	_____
_____	German measles	_____	_____	Frequent/severe headaches	_____
_____	Mumps	_____	_____	Difficulty concentrating	_____
_____	Chicken Pox	_____	_____	Memory problems	_____
_____	Whooping cough	_____	_____	Extreme tiredness or	
_____	Diphtheria	_____	_____	weakness	_____
_____	Scarlet fever	_____	_____	Rheumatic fever	_____
_____	Meningitis	_____	_____	Epilepsy	_____
_____	Encephalitis	_____	_____	Tuberculosis	_____
_____	High fever	_____	_____	Bone or joint disease	_____
_____	Convulsions	_____	_____	Gonorrhea or syphilis	_____
_____	Allergy	_____	_____	Anemia	_____
_____	Hay fever	_____	_____	Jaundice/hepatitis	_____
_____	Injuries to head	_____	_____	Diabetes	_____
_____	Broken bones	_____	_____	Cancer	_____
_____	Hospitalizations	_____	_____	High blood pressure	_____
_____	Operations	_____	_____	Heart disease	_____
_____	Ear problems (disease, infection, injury or impaired hearing)	_____	_____	Asthma	_____
_____	Visual problems	_____	_____	Bleeding problems	_____
_____	Fainting spells	_____	_____	Eczema or hives	_____
_____	Loss of consciousness	_____	_____	Suicide attempt	_____
_____	Paralysis	_____	_____	Other _____	_____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child.

Check	Condition	Relationship to child	Check	Condition	Relationship to child
<input type="checkbox"/>	Alcoholism	_____	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	Cancer	_____	<input type="checkbox"/>	Learning disability	_____
<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	ADHD	_____
<input type="checkbox"/>	Heart trouble	_____	<input type="checkbox"/>	Mental Retardation	_____
<input type="checkbox"/>	Bipolar Disorder	_____	<input type="checkbox"/>	Anxiety Disorder	_____
<input type="checkbox"/>	Anxiety Disorder	_____	<input type="checkbox"/>	Other	_____

OTHER INFORMATION

What are your child's favorite activities?

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

What activities would your child like to engage in more often than he/she does at present?

1. _____ 2. _____ 3. _____

What activities does your child like least?

1. _____ 2. _____ 3. _____

Has your child ever been in trouble with law? Yes _____ No _____

If yes, please describe briefly: _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check	<u>Disciplinary technique</u>	Check	<u>Disciplinary technique</u>
<input type="checkbox"/>	Ignore problem behavior	<input type="checkbox"/>	Tell child to sit on chair
<input type="checkbox"/>	Scold child	<input type="checkbox"/>	Send child to his or her room
<input type="checkbox"/>	Spank child	<input type="checkbox"/>	Take away some activity or food
<input type="checkbox"/>	Threaten child	<input type="checkbox"/>	Other technique (describe) _____
<input type="checkbox"/>	Reason with child	<input type="checkbox"/>	Redirect child's interest
<input type="checkbox"/>	Don't use any technique		

Which disciplinary techniques are usually effective? _____

With what type of problem(s)? _____

Which disciplinary techniques are usually ineffective? _____

With what type of problem(s)? _____

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

What are your child's assets or strengths? _____

***I think it would be helpful for Dr. McCaskill to contact the following professionals, who also participate (or have participated) in the care of my child (i.e., physicians, therapists, teachers, tutors, etc.):**

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

Name: _____

Profession: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

**Please see Dr. McCaskill to sign a written request so that she may contact the professionals cited above.*