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Child, Adolescent & Family Psychology

The Family History Questionnaire

This questionnaire concerns you and your child. I am asking you to complete this questionnaire to assist me in focusing on the concerns you have, and to better understand your child. Some of the information requested may not seem related to your child and his/her problems, but often such seemingly unrelated information becomes very important in my understanding your questions. You may not immediately remember the answers to all of the questions. However, I would appreciate your trying to complete the questionnaire as accurately and completely as possible. Family members, baby books, and close friends etc., can be good resources in completing this questionnaire. If you run out of space in answering a question, feel free to attach a sheet of paper. Your completion of this questionnaire **will help reduce the time needed to make an accurate evaluation of your child's difficulties** as well as help to focus my attention to your specific concerns. If you do not understand any of the questions please feel free to call me at the number listed below.

1300 Clear Springs Trace, Suite 7 ■ Louisville, KY 40223-3868 ■ 502.425.5422 ■ Fax502.425.5424

Today's date: _____

Child's First Name:_____ **Middle:**_____ Last:_____

Birthdate:_____ Current Age:_____ Gender: Male ____ Female ____ Non-Binary ____

Grade: _____ School: _____

Child's Primary Home address:_____

_____
City State Zip Code

Child's Cellular Phone: _____ Child's Email: _____

Mother's Name (First, Middle Initial & Last): _____

Mothers's Primary Home address:_____

_____
City State Zip Code

Birthdate: _____ Age: _____
Relationship to child: (check one) Biological ____ Adoptive ____ Stepmother ____ Other ____

Occupation: _____ Religion: _____
Ethnic Background: _____ Place of Birth: _____
Years in School: _____ Date of this marriage: _____
Place employed: _____ Years with Employers: _____
Work Hours: _____ Work Phone: _____
Cellular Phone: _____ E-Mail: _____

Father's Name (First, Middle Initial & Last): _____

Father's Primary Home address:_____

_____
City State Zip Code

Birthdate: _____ Age: _____
Relationship to child: (check one) Biological ____ Adoptive ____ Stepfather ____ Other ____

Occupation: _____ Religion: _____
Ethnic Background: _____ Place of Birth: _____
Years in School: _____ Date of this marriage: _____
Place employed: _____ Years with Employers: _____
Work Hours: _____ Work Phone: _____
Cellular Phone: _____ E-Mail: _____

Who referred you to me? _____

What is it that concerns you most about your child? What problems are you having? _____
_____

When did these concerns begin? _____

Describe what you have tried to do about these problems: _____
_____
_____

In what other ways do you think your child can best be helped? _____
_____
_____

In what ways are these problems affecting yourself, other family members or your family as a whole?_____
_____
_____

Prenatal/Birth History

Did you have problems getting pregnant? _____
Was this a planned pregnancy? Yes ___ No ____ How did you feel about it? _____
During which month did you start prenatal care? _____
Did you take any medications during pregnancy (includes all medications, vitamins, birth control pills, etc.)

_____
Did you smoke during pregnancy? Yes ____ No ____ If so, when? _____
How many cigarettes a day? _____
How much alcohol did you consume during your pregnancy? Yes ____ No ____
Number of drinks a week: _____
Any drug use during the pregnancy? Yes ____ No ____
List drug(s): _____
Any illnesses during the pregnancy?

_____
The baby was born: (check one) on time ____ early* ____ late* ____ *By how many weeks? _____
Length of labor in hours: _____
Type of delivery: (check all that apply) Vaginal ____ Breech ____ Cesarean ____ Forceps ____
Baby's birth weight _____ Length _____ APGAR scores _____ (1-10)
Infant's condition: (check all that apply) Breathed immediately ____ Cried immediately ____ Required oxygen ____
Had Seizures ____ Required Intensive Care ____

Problems during the first week of life: (check any that apply) Incubator ____ Yellow skin ____
Bleeding ____ Infection ____ Special concerns: _____

Developmental History

As an infant/toddler did the child eat well? _____

As an infant/toddler, what was your child's sleep pattern? _____

<u>Please indicate the age in months when your child first did each of the following</u>.
If your child has not yet done it please write "No"; if you do not remember, write "DR".

Held head erect _____
Crawled _____
Stood alone _____
Walked holding on furniture _____
Sat alone _____
Pulled to stand _____
Smiled spontaneously _____
Feed self cracker _____

Walked without holding on _____
Ran with good control _____
Walked up steps _____
Rode a tricycle _____
Said "mama" or "dada" _____
Started toilet training _____
Put on clothes _____

Drank from a cup _____
Played peek-a-boo _____
Recognized parents _____
Showed fear with strangers _____
Spoke in three word sentences _____
Ended toilet training _____
Handedness (check one): left ____ right ____ both ____

Child's Health/Medical History

Please list the name & address of child's physician: _____
_____
_____
_____
_____

Does your child see any additional physicians/specialists? If yes, please note name and why: _____
_____
_____
_____
_____

Does the physician know your child well? Yes _____ No ____

Does your child take any medication? Yes ____ No _____
If yes, please list current medications with the dosage and schedule taken:

Medication	Dosage	Schedule	Approximate Date started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When was your child's last physical exam? _____
Child's current height and weight (approximate): Height _____ Weight _____

Please mark what childhood diseases your child has contracted: (LIST AGE)

Mumps _____ Age: _____
Chicken pox _____ Age: _____
Roseola _____ Age: _____
Whooping cough _____ Age: _____
3-day measles _____ Age: _____
7-day measles _____ Age: _____
Scarlet fever _____ Age: _____
Serious illnesses: _____ Age: _____
List any unusual complications: _____
Is your child up to date with his/her immunizations? Yes _____ No _____

Please mark if your child has had any of the following:
Accidents: _____
High fever, unknown cause: _____
Pneumonia: _____
Anemia: _____
Lead poisoning: _____
Urine infection: _____
Bowel disease: _____
Problem in bladder or bowel control: _____
Vision problems: _____
If yes, do he/she wear corrective lens? Yes ____ No ____
When was the last eye exam?: _____

Hearing: _____
Frequent ear infections: _____
Speech/Language problems: _____
Difficulties eating or feeding self: _____
Difficulties in: Swallowing ____ Chewing ___ Drooling ___
Foot problems: _____
Motor problems: _____
Skin abnormalities: _____
Allergies: _____
Seizures or convulsions: _____
Sleep difficulties: _____
Unusual fears: _____
Unusual behaviors: _____
Ingestion of drugs, cleaners or non-food items: _____
Other illnesses/problems: _____
_____
_____
Has the child even been hospitalized? (Name of hospital, date & reason for hospitalization):_____
_____
_____
_____
Has your child ever received any previous psychotherapy or counseling? Yes ____ No ____
If yes, describe reason and estimate length of treatment: _____
_____
_____
With whom & for how long? _____
_____
_____
What was the outcome of that treatment experience? _____
_____
_____
_____

School History

Has your child ever been in preschool? Yes _____ No _____
If yes, please list where and at what age: _____
_____

In order of attendance, list all of the schools your child has attended since Kindergarten:

School	Location (if out of town)	Grade Level	Years	Grades—A's, B's, C's, D's U's
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has your child ever been held back a grade in school? Yes ____ No ____ If yes, list Grade: _____
Has there ever been a problem in getting your child to go to school? Yes ____ No ____
Has your child ever been in special education? Yes ____ No ____ If yes, when, where, what kind:
_____

Has your child had remedial classes or tutoring? Yes ____ No ____ If so when, where, what kind:
_____

Has your child ever had psychological or psycho-educational testing? Yes ____ No ____
If yes, by whom and at what age was he or she assessed? _____
_____

Has your child ever been diagnosed with having a learning disability? Yes ____ No ____
If yes, describe: _____
Was he/she placed in a special classroom or program? _____

Does your child receive special accommodations or services at school? Yes ____ No ____
If yes, describe: _____

If your child has a 504 Plan or an Individual Education Plan (IEP), please note what is targeted:
(e.g., Since 2nd grade recognized as having ADHD and receives extended time when taking quizzes or tests, allowed preferential seating, can be re-cued if off-task, etc.)
_____
_____
_____

Has your child ever received any special services for speech/language, hearing or occupational therapy? Yes ____ No ____ If yes, describe: _____
_____
_____

What is your child's attitude toward school? _____
What are your child's current grades like? _____
How do these grades compare with his/her grades one year ago? _____
Other comments about school: _____
_____

Social Behavior & Activities

How does your child play and/or get along with other children at
At school _____
In the neighborhood _____
With siblings _____

What things does your child like to do? _____
_____
_____
_____
What do you consider to be some of your child's strengths? _____
_____
_____
Describe your child's personality: _____
_____
_____
What things/activities present the greatest difficulty for your child? _____
_____
_____
_____

What are your concerns about your child's social functioning? _____
_____
_____
_____
_____
_____

Family History

Please list all immediate family members (indicate if adopted, half or step-members)

Name	Age	Relationship	Living Where	Siblings- Current School/Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Marriages:	Name	Date married	Date Separated	Date of Divorce	Reason for Divorce
Mother:	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Are there any particular family stresses of which you are aware that may have a bearing on your child's problem? If yes, please describe: _____
_____
_____
_____
_____

Who currently lives in the home?_____
_____
_____

Has your child ever been separated from the family? Yes ___ No ____
If yes, list age, duration and reason: _____

If either parent has been married previously, and this child is not the natural child of one of the parents, please give information regarding the absent natural parent:

Name: _____ Age: _____
Address: _____
Phone: _____
Date of separation: _____ Date of divorce: _____
Reason for divorce: _____
What type of custody arrangement was granted by the court? _____
(e.g., Joint Custody, Solo Custody, etc.)

What is the nature & frequency of your child's contacts with the absent parent? Please note the visitation schedule and how regular the schedule is followed: _____
_____
_____

What difficulties, if any, do any of the other children in the family have? _____
_____
_____

List any concerns that you have regarding your family's current functioning? _____
_____
_____
_____
_____

Substance Abuse History

Do you have any concern or suspicion that your child is or ever has experimented with alcohol or drugs? Yes _____ No _____
If yes, level of concern: Little ____ Moderate ____ High ____
Known experimentation or usage? Yes ____ No ____

Explain, if yes, on the next page (when did this occur, elaborate on details and name specific drugs):
_____

Family Medical/Family Psychiatric History

Please indicate whether there are any relatives of your child (including parents, grandparents, aunts, uncles and cousins), who have (or have had in the past) the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses or abnormalities such as birth defects, miscarriages, diabetes, seizures or epilepsy, mental or emotional disorders, substance abuse problems, slow development, mental retardation, school problems, cerebral palsy, muscular disorders, cancers, leukemia, thyroid disease, deafness or blindness, speech or language problems, reading or learning disabilities. (Please be as specific as possible, giving **relationship to the child, age of relative and problem**).

Mother_____
Mother's mother_____
Mother's father_____
Mother's brothers & sisters_____
Mother's maternal grandmother_____
Mother's maternal grandfather_____
Mother's paternal grandmother_____
Mother's paternal grandfather_____
Mother's aunts & uncles_____
Mother's cousins_____
Father_____
Father's mother_____
Father's father_____
Father's brothers & sisters_____
Father's maternal grandmother_____
Father's maternal grandfather_____
Father's paternal grandmother_____
Father's paternal grandfather_____
Father's aunts & uncles_____
Father's cousins_____

If you would like to provide any additional information, which you feel would be important for understanding your child and your concerns, please use the space below or on the back side of this sheet. Rev. 4/20