



ELAINE A. THOMAS PSY.D.

BACKGROUND QUESTIONNAIRE

FAMILY DATA

Child's name _____ Today's date _____

Birthdate _____ Age _____ Sex: Male Female

Home address _____

School _____ Teacher _____

Person(s) filling out this form: Mother Father Stepmother Stepfather Caregiver

Other (please explain) _____

Mother's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Father's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepmother's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepfather's name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Marital status of parents _____ If separated or divorced, how old was the child when the separation occurred? _____

If remarried, how old was the child when the stepparent entered the family? _____

List all people living in the household (please list additional people on a separate sheet if necessary):

<i>Name</i>	<i>Sex</i>	<i>Relationship to Child</i>	<i>Age</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List the name, sex, relationship to child, and age of any brothers, sisters, or other significant people living outside the home: _____

Dominant language spoken in the home _____ Other languages spoken in the home _____

What language does the child use to speak to you? _____

What language does the child use to speak with friends? _____

Was the child adopted? Yes No If yes, at what age? _____ Does the child know? Yes No

Name of medical coverage group or insurance company (if none, write "none") _____

Name of medical provider _____

If insured, insured's name _____

If referred, who referred you here? _____

(Continued)

PRESENTING PROBLEM

Briefly describe the 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? _____

Have you noticed changes in the child's abilities? Yes No

If yes, please describe: _____

Have you noticed changes in the child's behavior? Yes No

If yes, please describe: _____

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 being treated for a medical illness? Yes No

If yes, for what condition is the child being treated? _____

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

If yes, please note the kind of medication: _____

SOCIAL AND BEHAVIORAL CHECKLIST

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Has difficulty with hearing | <input type="checkbox"/> Breaks objects deliberately | <input type="checkbox"/> Eats poorly |
| <input type="checkbox"/> Has difficulty with vision | <input type="checkbox"/> Lies (describe) _____ | <input type="checkbox"/> Is stubborn |
| <input type="checkbox"/> Has difficulty with coordination | <input type="checkbox"/> Steals (describe) _____ | <input type="checkbox"/> Has poor bowel control (soils self) |
| <input type="checkbox"/> Has difficulty with balance | <input type="checkbox"/> Injures self often | <input type="checkbox"/> Is much too active |
| <input type="checkbox"/> Has difficulty making friends | <input type="checkbox"/> Runs away | <input type="checkbox"/> Is fidgety |
| <input type="checkbox"/> Has difficulty keeping friends | <input type="checkbox"/> Has low self-esteem | <input type="checkbox"/> Is easily distracted |
| <input type="checkbox"/> Refuses to share | <input type="checkbox"/> Blames others for his or her troubles | <input type="checkbox"/> Is disorganized |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Is argumentative | <input type="checkbox"/> Is clumsy |
| <input type="checkbox"/> Does not get along well with brothers/
sisters | <input type="checkbox"/> Does not get along well with other
children | <input type="checkbox"/> Is unusually talkative |
| <input type="checkbox"/> Does not get along well with adults | <input type="checkbox"/> Fights verbally with other children | <input type="checkbox"/> Is forgetful |
| <input type="checkbox"/> Fights verbally with adults | <input type="checkbox"/> Fights physically with other children | <input type="checkbox"/> Has blank spells |
| <input type="checkbox"/> Fights physically with adults | <input type="checkbox"/> Does not show feelings | <input type="checkbox"/> Daydreams too much |
| <input type="checkbox"/> Yells and calls children names | <input type="checkbox"/> Has frequent crying spells | <input type="checkbox"/> Worries a lot |
| <input type="checkbox"/> Shows wide mood swings | <input type="checkbox"/> Has unusual or special fears, habits,
or mannerisms (describe) _____ | <input type="checkbox"/> Is impulsive |
| <input type="checkbox"/> Is aggressive (describe) _____ | <input type="checkbox"/> Wets bed | <input type="checkbox"/> Takes unnecessary risks |
| <input type="checkbox"/> Is withdrawn (describe) _____ | <input type="checkbox"/> Bites nails | <input type="checkbox"/> Gets hurt frequently |
| <input type="checkbox"/> Is shy or timid | <input type="checkbox"/> Sucks thumb | <input type="checkbox"/> Has too many accidents |
| <input type="checkbox"/> Clings to others | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Doesn't learn from experience |
| <input type="checkbox"/> Tires easily, has little energy | <input type="checkbox"/> Has trouble sleeping (describe) _____ | <input type="checkbox"/> Feels that he or she is bad |
| <input type="checkbox"/> Is more interested in things (objects)
than in people | <input type="checkbox"/> Rocks back and forth | <input type="checkbox"/> Is slow to learn |
| <input type="checkbox"/> Engages in behavior that could be
dangerous to self or others (describe) _____ | <input type="checkbox"/> Bangs head | <input type="checkbox"/> Moves slowly |
| | <input type="checkbox"/> Holds breath | <input type="checkbox"/> Stares into space for long periods |
| | | <input type="checkbox"/> Engages in stereotyped behavior
(describe) _____ |
| | | <input type="checkbox"/> Does not understand other people's
feelings |
| | | <input type="checkbox"/> Has difficulty following directions |
| | | <input type="checkbox"/> Gives up easily |

(Continued)

- Complains of aches or pains
- Is disobedient
- Gets into trouble with the law
- Constantly seeks attention
- Is restless
- Has periods of confusion or disorientation
- Is jealous (describe) _____

- Is extremely selfish
- Feels hopeless
- Is nervous or anxious

- Is immature
- Is easily frustrated
- Has difficulty learning when there are distractors
- Is suspicious of other people
- Requires constant supervision
- Has difficulty resisting peer pressure
- Shows anger easily
- Has difficulty accepting criticism
- Feels sad or unhappy often
- Talks about wanting to die
- Has poor attention span

- Has poor memory
- Sets fires
- Is afraid of new situations
- Has trouble making plans
- Eats inedible objects
- Is not toilet trained
- Uses illegal drugs (describe) _____

- Drinks alcohol
- Other problems (describe) _____

Place a check next to any behavior or problem that the child has shown *within the last three months*.

- Shows sexually provocative behavior
- Has extreme fear of bathroom or bathing
- Has anxiety when separated from parents
- Has extreme anxiety about going to school
- Has fear at bedtime
- Is wary of any physical contact with adults in general

- Refuses to sleep alone
- Refuses to go to bed
- Has loss of bladder control
- Is fearful of strangers
- (In cases of divorce) Is fearful of visiting a parent or caregiver
- Overeats
- Is very eager to please others
- Refuses to undress for physical education classes at school

- Has compulsion about cleanliness—wanting to wash or feeling dirty all the time
- Appears dazed, drugged, or groggy upon return from visiting a divorced or separated parent
- Other recent behaviors or problems (describe) _____

LANGUAGE/SPEECH CHECKLIST

Place a check next to any language or speech problem that the child *currently* exhibits.

- Speaks in shorter sentences than expected for age
- Does not know names of common objects
- Has difficulty recalling familiar words
- Substitutes vague words (e.g., "thing") for specific words
- Responds better to gestures than to words
- Does not make appropriate gestures to communicate

- Uses gestures instead of words to express ideas
- Has difficulty making speech understood
- Speaks very slowly
- Speaks too fast
- Is often hoarse
- Has unusually loud speech
- Has unusually soft speech
- Makes sounds but no words
- Mixes up the order of events

- Seems uninterested in communicating
- Prefers to speak to adults only
- Prefers to speak to children only
- Prefers to speak to family members only
- Speaks in a monotone or exaggerated manner

EDUCATIONAL CHECKLIST

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

- Has difficulty with reading
- Has difficulty with arithmetic
- Has difficulty with spelling
- Has difficulty with handwriting
- Has difficulty with other subjects (please list) _____

- Has difficulty paying attention in class
- Has difficulty sitting still in class
- Has difficulty waiting turn in school
- Has difficulty taking notes in class
- Has difficulty respecting others' rights
- Has difficulty remembering things
- Forgets homework

- Has difficulty getting along with teacher
- Has difficulty getting along with other children
- Dislikes school
- Resists going to school
- Refuses to do homework

Did the child attend preschool? Yes No

If yes, at what ages? _____ How often? _____

At what age did the child begin kindergarten? _____ What is his or her current grade? _____

Is the child in a special education class? Yes No

If yes, what type of class? _____

(Continued)

Has the child been held back in a grade? Yes No

If yes, what grade and why? _____

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

If yes, please describe: _____

Has the child's school performance become poorer recently? Yes No

If yes, please describe: _____

Has the child missed a lot of school? Yes No

If yes, please indicate reasons: _____

DEVELOPMENTAL HISTORY

Pregnancy

Did the mother have any problems during pregnancy? Yes No Don't know

If yes, what kind? _____

How old was the mother when she became pregnant? _____ Was this a first pregnancy? Yes No

If no, how many times was the mother previously pregnant? _____

During pregnancy, did the mother smoke? Yes No Don't know

If yes, how many cigarettes each day? _____

During pregnancy, did the mother drink alcoholic beverages? Yes No Don't know

If yes, what did she drink? _____ Approximately how much alcohol was consumed each day? _____

During which part of pregnancy—1st trimester, 2nd trimester, 3rd trimester—was the alcohol consumed? _____

Were there times when 5 or more drinks were consumed? Yes No Don't know

If yes, during which trimester—1st trimester, 2nd trimester, 3rd trimester? _____

During pregnancy, did the mother use drugs (including prescription, over-the-counter, and recreational)? Yes No Don't know

If yes, what kind? _____

During pregnancy, was the mother exposed to any x-rays or chemicals? Yes No Don't know

If yes, what kind? _____

During pregnancy, was the mother exposed to any infectious disease? Yes No Don't know

If yes, what disease? _____

During pregnancy, did the mother receive prenatal care? Yes No Don't know

Was delivery induced? Yes No Don't know

How long was labor? _____ Were forceps used during delivery? Yes No Don't know

Was a cesarean section performed? Yes No Don't know

If yes, for what reason? _____

Were there any complications associated with the delivery? Yes No Don't know

If yes, what kind? _____

Was the child premature? Yes No Don't know

If yes, by how many weeks? _____

Was neonatal care needed? Yes No Don't know

If yes, what kind of care and how long was it needed? _____

(Continued)

Infancy

What was the child's birthweight? _____ 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: _____

Were there any other 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 As an infant, did the child grow normally? Yes No

If no, please describe: _____

As an infant, was the child different in any way from siblings? Yes No Not applicable

If yes, please describe: _____

First Years

During the child's first years, did he or she show any of the following behaviors? Place a check next to each one that he or she showed.

- | | | |
|---|--|---|
| <input type="checkbox"/> Did not enjoy cuddling | <input type="checkbox"/> Had fine-motor problems | <input type="checkbox"/> Had peculiar patterns of speech |
| <input type="checkbox"/> Was not calmed by being held | <input type="checkbox"/> Had gross-motor problems | <input type="checkbox"/> Preferred to play alone |
| <input type="checkbox"/> Was colicky | <input type="checkbox"/> Did not babble | <input type="checkbox"/> Had poor eye contact |
| <input type="checkbox"/> Was excessively restless | <input type="checkbox"/> Did not speak | <input type="checkbox"/> Was not interested in other children |
| <input type="checkbox"/> Had poor sleep patterns | <input type="checkbox"/> Had excessive fears | <input type="checkbox"/> Did not smile socially |
| <input type="checkbox"/> Banged head frequently | <input type="checkbox"/> Ignored toys | <input type="checkbox"/> Was insensitive to cold or pain |
| <input type="checkbox"/> Was constantly into everything | <input type="checkbox"/> Was attached to an unusual object | <input type="checkbox"/> Did not wave bye-bye |
| <input type="checkbox"/> Had an excessive number of accidents | (describe) _____ | |
| <input type="checkbox"/> Was exposed to lead | <input type="checkbox"/> Was unaware of painful bumps or falls | |

Were there any other 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 the 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 or don't know the age at which the behavior occurred, please write a question mark. If the child has not yet demonstrated the behavior, write an X.

<i>Behavior</i>	<i>Age</i>	<i>Behavior</i>	<i>Age</i>	<i>Behavior</i>	<i>Age</i>
Showed response to mother	_____	Babbled	_____	Played pat-a-cake or peek-a-boo	_____
Held head erect	_____	Spoke first word	_____	Took off clothing alone	_____
Rolled over	_____	Showed fear of strangers	_____	Put on clothing alone	_____
Sat alone	_____	Put several words together	_____	Tied shoelaces	_____
Crawled	_____	Become toilet trained during day	_____	Rode tricycle	_____
Stood alone	_____	Stayed dry at night	_____	Named colors	_____
Walked alone	_____	Drank from cup	_____	Said alphabet in order	_____
Ran with good control	_____	Fed self	_____		

(Continued)

CHILD'S MEDICAL HISTORY

Place a check next to any illness or condition that the child has had. When you check an item, also note the approximate age of the child when he or she had the illness or condition.

<i>Illness or condition</i>	<i>Age</i>	<i>Illness or condition</i>	<i>Age</i>	<i>Illness or condition</i>	<i>Age</i>
<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Bone or joint disease	_____
<input type="checkbox"/> German measles	_____	<input type="checkbox"/> Broken bones	_____	<input type="checkbox"/> Gonorrhea or syphilis	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Hearing problems	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Ear infections	_____	<input type="checkbox"/> Jaundice/hepatitis	_____
<input type="checkbox"/> Whooping cough	_____	<input type="checkbox"/> Seeing problems	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Fainting spells	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Polio	_____	<input type="checkbox"/> Loss of consciousness	_____	(list type) _____	
<input type="checkbox"/> Scarlet fever	_____	<input type="checkbox"/> Paralysis	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Frequent headaches	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> High fever	_____	<input type="checkbox"/> Difficulty concentrating	_____	<input type="checkbox"/> Bleeding problems	_____
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> Memory problems	_____	<input type="checkbox"/> Eczema or hives	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Extreme tiredness	_____	<input type="checkbox"/> Suicide attempt(s)	_____
(please list) _____		<input type="checkbox"/> Rheumatic fever	_____	<input type="checkbox"/> Sleeping problems	_____
<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> HIV	_____
<input type="checkbox"/> Injuries to head	_____	<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> AIDS	_____

Does the child have any disabilities? Yes No If yes, please describe: _____

Has the child had any serious illnesses? Yes No If yes, what illnesses? _____

Has the child been hospitalized? Yes No If yes, please list reasons: _____

Has the child had any operations? Yes No If yes, please list reasons: _____

Has the child had any accidents? Yes No If yes, please describe: _____

Are the child's immunizations up to date? Yes No Child's height _____ Child's weight _____

FAMILY MEDICAL HISTORY

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

	<i>Relationship of family member to child</i>		<i>Relationship of family member to child</i>
<input type="checkbox"/> Academic problem	_____	<input type="checkbox"/> Emotional problem	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart trouble	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Neurological disease	_____
<input type="checkbox"/> Developmental problem	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Other problems (please list)	_____
<input type="checkbox"/> Drug problem	_____		_____

(Continued)

OTHER INFORMATION

Child's Activities

What are the child's favorite activities?

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

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

1. _____ 2. _____ 3. _____

What activities does the child like least?

1. _____ 2. _____ 3. _____

What chores does the child do around the house? _____

Has there been any recent change in his or her ability to carry out these chores? Yes No

If yes, please describe the change: _____

What time does the child usually go to bed on weekdays? _____ On weekends? _____

Trouble with the Law

Has the child ever been in trouble with the law? Yes No

If yes, please describe briefly: _____

Referral to Child Protective Services or Similar Agency

Has the child ever been referred to Child Protective Services or another similar agency for having been maltreated? Yes No

If yes, please describe briefly: _____

Your Use of Disciplinary Techniques

Place a check next to each technique that you commonly use when the child behaves inappropriately. There also is space for writing in any other disciplinary techniques that you use.

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

Which disciplinary techniques are usually effective? _____

With what types of problems? _____

Which disciplinary techniques are usually ineffective? _____

With what types of problems? _____

Which parent (caregiver) usually administers discipline? _____

Activities Checklist

Place a check next to each activity that the child can do by himself or herself (even if the child does not do the activity regularly).

- | | | |
|--|--|--|
| <input type="checkbox"/> Sets table | <input type="checkbox"/> Helps with grocery shopping | <input type="checkbox"/> Puts clothes away |
| <input type="checkbox"/> Cooks meals | <input type="checkbox"/> Unpacks groceries | <input type="checkbox"/> Sews |
| <input type="checkbox"/> Cleans table | <input type="checkbox"/> Does laundry | <input type="checkbox"/> Empties garbage |
| <input type="checkbox"/> Washes dishes | <input type="checkbox"/> Does ironing | <input type="checkbox"/> Does homework alone |

Child's Responsibilities

Can the child be trusted to care for a pet? Yes No

If no, why not? _____

Does the child handle his or her personal finances? Yes No

If no, why not? _____

Does the child take responsibility for his or her personal hygiene? Yes No

If no, why not? _____

Is the child's behavior generally age appropriate? Yes No

If no, please describe in what ways it is not age appropriate: _____

Other Areas

What do you enjoy doing with the child? _____

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

What are the child's assets or strengths? _____

Is there any other information that you think may help us in working with the child? _____

What prompted you to seek help at this time? _____

Family Stress Survey

Every family sometimes experiences some form of stress. Please put a check next to each event that your family has experienced in the last 12 months. There also is a place for listing other types of stresses that your family experienced in the last 12 months.

- Child's mother died.
- Child's father died.
- Child's brother died.
- Child's sister died.
- Parents divorced.
- Parents separated.
- Grandparent died.
- Someone in family was seriously injured or became ill (list person): _____
- Parent remarried.
- Father lost job.
- Mother lost job.
- Family moved to another city.

- Family moved to another part of town.
- Someone in family was in trouble with the law or police (list person): _____
- Family's financial condition changed.
- Member of family was accused of child abuse or neglect (list person): _____
- Neighborhood was changing for the worse.
- Child was a victim of violence.
- Family experienced a natural disaster (list): _____

- Child started having trouble with parents (caregiver).
- Child started having trouble with sisters/brothers.
- Child started having trouble in school.
- Child changed schools.
- Child's close friend moved away.
- Child's pet died.
- Other types of stresses (list): _____
- _____
- _____
- _____

Parent Needs Survey^a

Listed below are some needs commonly expressed by parents (caregivers). Please put a check next to each item if you need help in that area.

- More information about the child's abilities.
- Someone who can help me feel better about myself.
- Help with child care.
- More money/financial help.
- Someone who can babysit for a day or evening so that I can get away.
- Better medical care for the child.
- Better dental care for the child.
- More information about child development.
- More information about behavior problems.
- More information about programs that can help the child.
- Help communicating with the child's school.
- Someone to help with household chores.
- Counseling to help me cope with my situation.
- Better therapy services for the child.
- Day care so that I can get a job.
- A bigger or better house or apartment.
- More information about how I can help the child.
- More information about nutrition or feeding.
- Assistance in handling other children's jealousy of their brother or sister.
- Health insurance.
- Vocational training for me.
- Assistance in dealing with problems with in-laws or other relatives.
- Assistance in dealing with problems with friends or neighbors.
- Special equipment to meet the child's needs.
- Opportunities to meet people who have a child like mine.
- Someone to talk to about my problems.
- Assistance in dealing with problems with my husband/wife/partner.
- A car or other form of transportation.
- Medical care for myself.
- More time for myself.
- More time to be with the child.
- More time to be with my spouse/partner.
- More time to be with other adults.
- A vacation.
- Other needs (list)

Thank you.