

Twin State Psychological Services

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Offices In:
Springfield & Ludlow, VT
Claremont & Charlestown, NH

Child Background Questionnaire

*** Confidential ***

The following is a detailed questionnaire regarding your child's development, medical history, and current functioning at home and at school. This information will be integrated with the testing results to provide a better picture of your child's abilities as well as any problem areas. Thank you for completing this questionnaire.

Child's Name: _____ **Today's Date:** _____

Birthdate: _____ **Age:** _____ **Grade:** _____ **Name of School:** _____

Person filling out this form: Mother Father Stepmother Stepfather Other: _____

Biological Mother's Name: _____ **Age:** _____ **Highest Grade Completed:** _____

Number of Years of Education: _____ **Degree/Diploma (if applicable):** _____

Occupation: _____

Biological Father's Name: _____ **Age:** _____ **Highest Grade Completed:** _____

Number of Years of Education: _____ **Degree/Diploma (if applicable):** _____

Occupation: _____

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 Other: _____

Stepparent's Name: _____ Age: _____ Occupation: _____

Stepparent's Name: _____ Age: _____ Occupation: _____

If this child is not living with either biological parent:

Reason: _____

Adoptive parents Foster parents Other family Group home Other: _____

List all people in your child's family:

Name	Relationship to Client	Age	Psychological/Medical Problems
------	------------------------	-----	--------------------------------

Name: _____

Who Referred You To Our Office? _____

What are the Reasons You are Having this Assessment Completed?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Name(s), Address(es) and Phone Number(s) of Legal Guardian(s):

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Permission to Provide Professional Services to My Child:

We generally need to have a child's guardian(s)/both biological parents' permission for your child to receive professional services from our office, unless we have copies of a legal document indicating otherwise. If you are the child's biological parents and living together, we will usually give you one Child Background Questionnaire to complete - you should both provide permission for your child to receive professional services from our office through your signatures below. If you are separated, we will give you two Child Background Questionnaire to complete, and you should both provide permission for your child to receive professional services from our office through your signature on the Child Background Questionnaire you receive. Either or both parent are able to obtain copies of our records for their child, unless we have copies of a legal document indicating otherwise. Through my signature below, I give Twin State Psychological Services permission to provide professional services to my child.

Parent's/Guardian's Signature

Parent's/Guardian's Signature

Date

Date

Current Medications

List *all* medications that your child is currently taking:

Medication	Reason taken	Dosage (if known)	Start Date

Name: _____

Educational Program

Does your child have a modified learning program: Yes No

Is there an individual education plan (IEP)? Yes No

Are you satisfied with your child's current learning program: If not, please explain: _____

Has your child been held back a grade: Yes No (indicate grade: _____)

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

Is your child receiving learning 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? Yes No If yes, please describe: _____

Briefly describe 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	Severe Problem
Speech				
Comprehension of speech				
Problem solving				
Attention span				
Organizational skills				
Remembering events				
Remembering facts				
Learning from experience				
Understanding concepts				
Overall intelligence				

Check any specific problems:

- | | |
|---|--|
| <input type="checkbox"/> Poor articulation | <input type="checkbox"/> Frequently forgets instructions |
| <input type="checkbox"/> Difficulty finding words to express self | <input type="checkbox"/> Frequently loses belongings |
| <input type="checkbox"/> Disorganized speech | <input type="checkbox"/> Difficulty planning tasks |
| <input type="checkbox"/> Talks like a younger child | <input type="checkbox"/> Doesn't foresee consequences of actions |
| <input type="checkbox"/> Slow learner | <input type="checkbox"/> Slow thinking |
| <input type="checkbox"/> Forgets to do things | <input type="checkbox"/> Difficulty with math/handling money |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Poor understanding of time |

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

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

Developmental History¹

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 or blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc.): _____

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

Were there any indications of fetal distress: Yes No

If yes on any of above, for what reason? _____

Check any that apply to the birth: Labor induced Forceps Breech Cesarean

If yes on any of above, for what reason? _____

What was your child's birth weight? _____

Check any that apply following birth: Jaundice Breathing problems Incubator Birth defect

If any, please describe: _____

Were there any other 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 growth or development problems during the first few years of life: Yes No

If yes, please describe: _____

¹ If your child is adopted, please fill in as much of the following information as you are aware of.

Name: _____

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

- Unusually quiet or inactive
- Colic
- Headbanging
- Did not like to be held or cuddled
- Excessive restlessness
- Constantly into everything
- Not alert
- Excessive sleep
- Diminished sleep
- Difficult to soothe
- More accidents compared with other children

Please indicate the approximate age at which your child first showed the following behaviors by checking the appropriate box. Check "never" if your child has never shown the listed behavior.

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

Medical History

Vision problems No Yes (describe): _____ Date of last vision exam: _____
 Hearing problems No Yes (describe): _____ Date of last hearing exam: _____

Place a check next to any illness or condition your child has had. When you check an item, also note the approximate date of the illness (if you prefer, you can simply indicate the child's age at illness).

<i>Illness or Condition</i>	<i>Date(s) or age(s)</i>	<i>Illness or Condition</i>	<i>Date(s) or age(s)</i>
___ Measles	_____	___ Loss of consciousness	_____
___ German measles	_____	___ Poisoning	_____
___ 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	_____	___ Physical abuse	_____
___ Operations	_____	___ Sexual abuse	_____
___ Ear infections	_____	___ Other:	_____
___ Paralysis	_____		_____

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.

<i>Condition</i>	<i>Relationship to child</i>
___ Seizures or epilepsy	_____
___ Attention deficit	_____
___ Hyperactivity	_____
___ Learning disabilities	_____
___ Mental retardation	_____
___ Tics or Tourette's syndrome	_____
___ Alcohol abuse	_____
___ Drug abuse	_____
___ Suicide attempt	_____
___ Physical abuse	_____
___ Childhood behavior problems	_____
___ Mental illness	_____
___ Depression or anxiety	_____
___ Sexual abuse	_____
___ Neurological illness or disease	_____
___ Antisocial behavior (assaults, thefts, etc.)	_____

Name: _____

Previous Assessment: List any previous assessments that your child has had:

	<i>Dates of testing</i>	<i>Name of examiner</i>
Psychological	_____	_____
	_____	_____
Neuropsychological	_____	_____
	_____	_____
Psychiatric	_____	_____
	_____	_____
Educational	_____	_____
	_____	_____
Speech pathology	_____	_____
	_____	_____

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

<i>Type of treatment</i>	<i>Dates</i>	<i>Name of therapist</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Abuse/Stressors/Trauma: Have there been any abuse/stressors/traumas that you think may be contributing to your child's difficulties (e.g., sexual trauma, physical abuse, emotional/verbal abuse, illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, other losses)?

Other Information: What are your child's favorite activities? _____

Has your child ever been in trouble with the law? Yes No If yes, please describe briefly _____

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

What are your child's assets or strengths? _____

You will find on the following four pages a list of items that describe children. For each item circle the appropriate number to the left most descriptive of your child over the past 6 months. Please circle the 2 if the item is very true or often true. Circle the Number 1 if the item is somewhat or sometimes true. Circle the Number 0 if the item is not true of your child. Please answer all items as well as you can, even if some do not seem to apply.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

- | | | | | |
|---|---|---|-----|---|
| 0 | 1 | 2 | 1. | Acts too young for his/her age |
| 0 | 1 | 2 | 2. | Allergy (Describe): _____ |
| 0 | 1 | 2 | 3. | Argues a lot |
| 0 | 1 | 2 | 4. | Asthma |
| 0 | 1 | 2 | 5. | Behaves like opposite sex |
| 0 | 1 | 2 | 6. | Bowel movements outside toilet |
| 0 | 1 | 2 | 7. | Bragging, boasting |
| 0 | 1 | 2 | 8. | Can't concentrate/pay attention long |
| 0 | 1 | 2 | 9. | Can't get mind off certain thoughts/obsessions
Describe: |
| 0 | 1 | 2 | 10. | Can't sit still. Restless or hyperactive |
| 0 | 1 | 2 | 11. | Clings to adults/too dependent |
| 0 | 1 | 2 | 12. | Complains of loneliness |
| 0 | 1 | 2 | 13. | Confused or seems to be in a fog |
| 0 | 1 | 2 | 14. | Cries a lot |
| 0 | 1 | 2 | 15. | Cruel to animals |
| 0 | 1 | 2 | 16. | Cruelty/bullying or meanness to others |
| 0 | 1 | 2 | 17. | Daydreams, gets lost in thought |
| 0 | 1 | 2 | 18. | Deliberately harms self/attempts suicide |
| 0 | 1 | 2 | 19. | Demands a lot of attention |
| 0 | 1 | 2 | 20. | Destroys his/her things |
| 0 | 1 | 2 | 21. | Destroys things belonging to his/her family or other children |
| 0 | 1 | 2 | 22. | Disobedient at home |
| 0 | 1 | 2 | 23. | Disobedient at school |
| 0 | 1 | 2 | 24. | Doesn't eat well |
| 0 | 1 | 2 | 25. | Doesn't get along with other children |
| 0 | 1 | 2 | 26. | Doesn't seem to feel guilty after misbehaving |
| 0 | 1 | 2 | 27. | Easily jealous |
| 0 | 1 | 2 | 28. | Eats or drinks things that are not food |
| 0 | 1 | 2 | 29. | Fears certain animals, situations/places other than school |
| 0 | 1 | 2 | 30. | Fears school |
| 0 | 1 | 2 | 31. | Fears he/she might think/do something bad |
| 0 | 1 | 2 | 32. | Feels has to be perfect |
| 0 | 1 | 2 | 33. | Feels or complains that no one loves him/her |
| 0 | 1 | 2 | 34. | Feels others are out to get him/her |
| 0 | 1 | 2 | 35. | Feels worthless or inferior |
| 0 | 1 | 2 | 36. | Gets hurt a lot/accident prone |
| 0 | 1 | 2 | 37. | Gets in many fights |
| 0 | 1 | 2 | 38. | Gets teased a lot |
| 0 | 1 | 2 | 39. | Hangs around with children who get in trouble |
| 0 | 1 | 2 | 40. | Hears things that aren't there
Describe |
| 0 | 1 | 2 | 41. | Impulsive or acts without thinking |
| 0 | 1 | 2 | 42. | Likes to be alone |
| 0 | 1 | 2 | 43. | Lying or cheating |
| 0 | 1 | 2 | 44. | Biting fingernails |

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

- | | | | | |
|---|---|---|-----|--|
| 0 | 1 | 2 | 45. | Nervous, high strung or tense |
| 0 | 1 | 2 | 46. | Nervous movements or twitching. Describe: _____ |
| 0 | 1 | 2 | 47. | Nightmares |
| 0 | 1 | 2 | 48. | Not liked by other children |
| 0 | 1 | 2 | 49. | Constipated, doesn't move bowels |
| 0 | 1 | 2 | 50. | Too fearful or anxious |
| 0 | 1 | 2 | 51. | Feels dizzy |
| 0 | 1 | 2 | 52. | Feels too guilty |
| 0 | 1 | 2 | 53. | Overeating |
| 0 | 1 | 2 | 54. | Overtired |
| 0 | 1 | 2 | 55. | Overweight |
| 0 | 1 | 2 | 56. | Physical problems without known cause |
| 0 | 1 | 2 | A. | Aches or pains |
| 0 | 1 | 2 | B. | Headaches |
| 0 | 1 | 2 | C. | Nausea, feels sick |
| 0 | 1 | 2 | D. | Problems with eyes – Describe: _____ |
| 0 | 1 | 2 | E. | Rashes or other skin problems |
| 0 | 1 | 2 | F. | Stomach aches/cramps |
| 0 | 1 | 2 | G. | Vomiting, throwing up |
| 0 | 1 | 2 | H. | Other - Describe - Describe _____ |
| 0 | 1 | 2 | 57. | Physically attacks people |
| 0 | 1 | 2 | 58. | Picks nose, skin, or other parts of body
Describe _____ |
| 0 | 1 | 2 | 59. | Plays with own sex parts in public |
| 0 | 1 | 2 | 60. | Plays with own sex parts too much |
| 0 | 1 | 2 | 61. | Poor school work |
| 0 | 1 | 2 | 62. | Poorly coordinated or clumsy |
| 0 | 1 | 2 | 63. | Prefers playing with older children |
| 0 | 1 | 2 | 64. | Prefers playing with younger children |
| 0 | 1 | 2 | 65. | Refuses to talk |
| 0 | 1 | 2 | 66. | Repeats certain acts over and over |
| 0 | 1 | 2 | 67. | Runs away from home |
| 0 | 1 | 2 | 68. | Screams a lot |
| 0 | 1 | 2 | 69. | Secretive, keeps things to self |
| 0 | 1 | 2 | 70. | Sees things that aren't really there
Describe: _____ |
| 0 | 1 | 2 | 71. | Self-conscious or easily embarrassed |
| 0 | 1 | 2 | 72. | Sets fires |
| 0 | 1 | 2 | 73. | Sexual problems
Describe: _____ |
| 0 | 1 | 2 | 74. | Showing off or clowning around |
| 0 | 1 | 2 | 75. | Shy or timid |
| 0 | 1 | 2 | 76. | Sleeps less than most children |
| 0 | 1 | 2 | 77. | Sleeps more than most children during day/night
Describe: _____ |
| 0 | 1 | 2 | 78. | Smears bowel movements |
| 0 | 1 | 2 | 79. | Speech problem. Describe: _____ |
| 0 | 1 | 2 | 80. | Stares blankly |
| 0 | 1 | 2 | 81. | Steals at home |
| 0 | 1 | 2 | 82. | Steals outside the home |
| 0 | 1 | 2 | 83. | Stores up things he/she doesn't need |

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

- | | | | | |
|---|---|---|------|--|
| 0 | 1 | 2 | 84. | Strange Behavior
Describe: _____ |
| 0 | 1 | 2 | 85. | Strange ideas
Describe: _____ |
| 0 | 1 | 2 | 86. | Stubborn, sullen or irritable |
| 0 | 1 | 2 | 87. | Sudden changes in mood or feelings |
| 0 | 1 | 2 | 88. | Sulks a lot |
| 0 | 1 | 2 | 89. | Suspicious |
| 0 | 1 | 2 | 90. | Swearing or obscene language |
| 0 | 1 | 2 | 91. | Talks about killing self |
| 0 | 1 | 2 | 92. | Talks or walks in sleep - Describe: _____ |
| 0 | 1 | 2 | 93. | Talks too much |
| 0 | 1 | 2 | 94. | Teases too much |
| 0 | 1 | 2 | 95. | Temper tantrums or hot temper |
| 0 | 1 | 2 | 96. | Thinks about sex too much |
| 0 | 1 | 2 | 97. | Threatens people |
| 0 | 1 | 2 | 98. | Thumb sucking |
| 0 | 1 | 2 | 99. | Too concerned with neatness |
| 0 | 1 | 2 | 100. | Trouble sleeping – Describe: _____ |
| 0 | 1 | 2 | 101. | Truancy, skips school |
| 0 | 1 | 2 | 102. | Underactive/slow moving |
| 0 | 1 | 2 | 103. | Unhappy, sad or depressed |
| 0 | 1 | 2 | 104. | Unusually loud |
| 0 | 1 | 2 | 105. | Uses alcohol or drugs (including tobacco and caffeine) -
Describe type, frequency, etc. _____ |
| 0 | 1 | 2 | 106. | Vandalism |
| 0 | 1 | 2 | 107. | Wets self during day |
| 0 | 1 | 2 | 108. | Wets the bed |
| 0 | 1 | 2 | 109. | Whining |
| 0 | 1 | 2 | 110. | Wishes to be of opposite sex |
| 0 | 1 | 2 | 111. | Withdrawn/ doesn't get involved |
| 0 | 1 | 2 | 112. | Worrying |
| 0 | 1 | 2 | 113. | Thoughts of physically hurting others - Describe: _____ |
| 0 | 1 | 2 | 114. | Eats poorly |

Additional Social Development Questions

- | | | | | |
|---|---|---|------|--|
| 0 | 1 | 2 | 115. | More interested in objects than in people |
| 0 | 1 | 2 | 116. | Difficulty making friends |
| 0 | 1 | 2 | 117. | Teased by other children |
| 0 | 1 | 2 | 118. | Bullies other children |
| 0 | 1 | 2 | 119. | Not sought out for friendship by peers |
| 0 | 1 | 2 | 120. | Difficulty seeing another person's point of view |
| 0 | 1 | 2 | 121. | Doesn't empathize with others |
| 0 | 1 | 2 | 122. | Overly trusting of others |
| 0 | 1 | 2 | 123. | Doesn't appreciate humor |

Name: _____

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

Additional Behavior Questions

- | | | | | |
|---|---|---|------|---------------------------------------|
| 0 | 1 | 2 | 124. | Irritable, angry or resentful |
| 0 | 1 | 2 | 125. | Frequent tantrums |
| 0 | 1 | 2 | 126. | Strikes out at others |
| 0 | 1 | 2 | 127. | Throws or destroys things |
| 0 | 1 | 2 | 128. | Argues with adults |
| 0 | 1 | 2 | 129. | Stealing |
| 0 | 1 | 2 | 130. | Low frustration threshold |
| 0 | 1 | 2 | 131. | Daredevil behavior |
| 0 | 1 | 2 | 132. | Runs away |
| 0 | 1 | 2 | 133. | Needs a lot of supervision |
| 0 | 1 | 2 | 134. | Skips school |
| 0 | 1 | 2 | 135. | Overly preoccupied with details |
| 0 | 1 | 2 | 136. | Overly attached to certain objects |
| 0 | 1 | 2 | 137. | Not affected by negative consequences |
| 0 | 1 | 2 | 138. | Alcohol abuse |
| 0 | 1 | 2 | 139. | Sexually active |

Other Problems

- | | | | | |
|---|---|---|------|---|
| 0 | 1 | 2 | 140. | Bladder control problems (not during seizure) |
| 0 | 1 | 2 | 141. | Poor bowel control (soils self) |
| 0 | 1 | 2 | 142. | Overreacts to noises |
| 0 | 1 | 2 | 143. | Problems with taste or smell |

Motor Skills

- | | | | | |
|---|---|---|------|-------------------------------|
| 0 | 1 | 2 | 144. | Poor fine motor coordination |
| 0 | 1 | 2 | 145. | Poor gross motor coordination |

Please provide any additional comments you wish to make regarding your child: _____

**Thank you for answering these questions.
Your answers are most valuable in understanding your child.
We look forward to seeing you.**