

HISTORICAL INFORMATION QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____ Today's Date: _____
Child's School: _____ Grade: _____ Teacher(s): _____
Child's Physician: _____
Form Completed By: _____ Relationship to Child: _____

CURRENT BEHAVIORAL CONCERNS

What are your primary concerns about your child? _____

How have you tried to address these problems and what has been successful?

- Verbal reprimands (Successful: Yes No) Time Out (Successful: Yes No)
Removal of Privileges (Successful: Yes No) Physical punishment (Successful: Yes No)
Give in to the child (Successful: Yes No) Avoid the child (Successful: Yes No)
Other (Please Describe: _____)

On average, what percent of the time does your child follow directions without you having to repeat yourself?

0-20% 20-40% 40-60% 60-80% 80-100%

On average, what percent of the time does your child eventually follow directions?

0-20% 20-40% 40-60% 60-80% 80-100%

To what extent are you and your spouse consistent with respect to discipline?

Most of the time Some Seldom Never

Have any of the following stressful events occurred within the past 12 months? Parents divorced or separated

- Family accident or illness Death in family Parent changed jobs Changed schools
Family moved Family financial problems Other (Please specify _____)

From each group, circle any which apply. Indicate at what age problems first appeared:

- Difficulty staying seated Easily distracted Difficulty waiting turn
Often blurts out answers to questions Difficulty following instructions Difficulty sustaining attention
Shifts from one activity to another Difficulty playing quietly Talks too much
Often interrupts Often does not listen Often loses things
Fidgets Often engages in physically dangerous activities

At what age did above problems begin? _____

- Often loses temper Often argues with adults Often refuses to follow adult requests
Often annoys others on purpose Often angry and resentful Often spiteful or vindictive
Often blames others for own mistakes Often curses Is often touchy or easily annoyed by others

At what age did above problems begin? _____

Page 2
Historical Questionnaire

Unrealistic or persistent worry
about possible harm to loved ones
Avoidance of being alone
Refusal to sleep alone
Refusal to go to school

Unrealistic worry that a
terrible event will separate
the child from parent
Excessive physical complaints
Excessive distress in anticipation
of separation from parent

Excessive distress when
separated from home or parents
Repeated nightmares about
separation

At what age did above problems begin? _____

Unrealistic worry about future events
Unrealistic concern about competence

Inability to relax
Excessive need for reassurance

Marked self-consciousness
Unrealistic concern about past
behavior

At what age did above problems begin? _____

Decrease or increase in appetite
Feelings of hopelessness
Sleep disturbance
Low self esteem

Depressed or irritable mood
most of the day
Fatigue or loss of energy
Can't concentrate as well as (s)he used to

Feelings of worthlessness or
inappropriate guilt
Suicidal thought or behavior

At what age did above problems begin? _____

MEDICAL/DEVELOPMENTAL HISTORY

Mother's health during pregnancy: _____ Good _____ Fair _____ Poor _____ Don't Know

Mother's age when the child was born: _____

Did the mother use any of the following during pregnancy?

Alcohol: _____ Never _____ Once or twice _____ 3-19 times _____ Over 20 times

Tobacco: _____ Never _____ Once or twice _____ 3-19 times _____ Over 20 times

Medications taken during pregnancy: _____

Was the child born on schedule? _____ 8 mos or earlier _____ Term (8-10 mos) _____ Don't Know

Were there indications of fetal distress during labor or birth? _____ Yes _____ No _____ Don't Know

Was delivery: _____ Normal _____ Breech _____ Caesarian _____ Forceps _____ Induced

What was the child's birth weight? _____

Problems with pregnancy, labor, or delivery: _____

Health complications following birth: _____

Page 3
Historical Questionnaire

Were there any early infancy feeding problems: Yes No

Was the child colicky? Yes No

Were there early infancy sleep pattern difficulties? Yes No

Health problems during infancy? Yes No (If yes, please describe)

Did the child have any congenital problems (birth defects)? Yes No (If yes, please describe)

Was the child an easy baby (didn't cry a lot, followed a schedule well)?
 Very easy Easy Average Difficult Very Difficult

How did the baby behave with other people?
 More sociable than average Average sociability More unsociable than average

When (s)he wanted something, how insistent was (s)he?
 Very insistent Pretty insistent Average Not very insistent Not at all insistent

How would you rate the activity level of the child as an infant/toddler?
 Very active Active Average Less active Not active

At what age did (s)he walk? _____

At what age did (s)he speak single words (other than mama or dada)? _____

At what age did (s)he string two or more words together? _____

At what age was (s)he toilet trained? _____

Approximately how long did toilet training take? _____

How would you describe your child's current health? Good or Very Good Fair Poor

Current medical problems: _____

Current medications: _____

Hearing problems: Yes No (If yes, please describe)

Vision problems: Yes No (If yes, please describe)

Problems with coordination: Yes No (If yes, please describe)

Speech problems: Yes No (If yes, please describe)

Has (s)he had any chronic health problems? Yes No If yes, please describe: _____

Page 4
Historical Questionnaire

Which of the following illnesses has the child had? Mumps Chicken pox Measles
 Whooping cough Pneumonia Encephalitis Repeated Ear Infections
 Lead poisoning Seizures

Has the child had any accidents resulting in the following? Broken bones Severe Lacerations
 Head injury Stomach pumped Eye injury Lost teeth Sutures

Please list any surgeries and indicate when they were performed: _____

Do you suspect that the child uses alcohol or drugs? Yes No (If yes, please describe)

Does the child have any history of abuse? Yes No (If yes, please describe)

Does the child have any sleeping problems: Yes No (If yes, please describe)

Does the child wet the bed: Yes No If yes, how often? _____
If yes, has (s)he ever been dry for some period of time? Yes (How long? _____) No

Does the child have a bladder control problem during the day? Yes No (If yes, how often? _____)

Does the child have bowel control problems at night or during the day? Yes No (If yes, please describe)

Please describe the child's appetite: Overeats Average Undereats

TREATMENT HISTORY

Has the child ever been prescribed any of the following?
 Medicine for ADD/ADHD (what type? _____)
 Antidepressant medication Other medication for emotions/behavior
Please list _____

Please list past history of psychological treatment (counseling, hospitalization, etc): _____

SCHOOL HISTORY

Were any problems present during any of the following?
 Preschool Kindergarten Grades 1-12 (Which grades? _____)

Has the child ever been in any type of special education program? Learning Disabilities
 Behaviorally Emotionally Disabled Intellectual Impairment Speech Therapy
 Other (Please describe)

Has the child ever repeated a grade? Yes No (If yes, which grade(s)? _____)

Has the child ever been: Suspended from school In school-suspension Expelled from school
 Expelled from daycare center When? _____

Have any of the following approaches been tried in school? Behavior modification program
 Daily/weekly report card Other (Please describe)

SOCIAL HISTORY

Please describe child's relationship with brother(s)/sister(s): _____

How easily does the child make friends? Easier than average Average Worse than average

About how long does your child keep friendships? Less than 6 mos 6-12 mos More than 1 year

Please describe concerns about your child's social relationships: _____

FAMILY HISTORY

The child's parents are: Married (For how long _____) Divorced (Since _____) Never married

The child resides with: Both parents Mother only Father only Mother and Stepfather
 Father and Stepmother Other (Please specify)

Father's occupation: _____

Mother's occupation: _____

Stepfather's occupation (If applicable): _____

Stepmother's occupation (If applicable): _____

The current marital situation is: Stable Unstable (If unstable, please describe)

Has the mother ever been diagnosed with any psychological or psychiatric disorder? Yes No
If yes, please specify:

Has the father ever been diagnosed with any psychological or psychiatric disorder? Yes No
If yes, please specify:

Mother's level of education: _____

Father's level of education: _____

Did mother have any learning problems in school? Yes No (If yes, please describe)

Did mother receive any special education services? Yes No (If yes, what type? _____)

Is there any family history of Attention Deficit Hyperactivity Disorder on mother's side? Yes No

Page 6
Historical Questionnaire

Did father have any learning problems in school? ____Yes ____No (If yes, please describe)

Did father receive any special education services? ____Yes ____No (If yes, what type?_____)

Is there any family history of Attention Deficit Hyperactivity Disorder on father's side? ____Yes ____No

<u>Sibling's names</u>	<u>Sex</u>	<u>Age</u>	<u>Grade</u>
_____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___
_____	___	___	___

Are any of the child's siblings diagnosed with Attention Deficit Hyperactivity Disorder? ____Yes ____ No

Do any of the siblings have any other learning or psychological problems? ____ Yes ____ No
If yes, please describe:

Please use this space for comments: