Advanced Psychological Solutions

Gerard Boutin Ph.D. PA
Clinical Psychology / Neuropsycholgy

13787 Belcher Rd. South
Suite 140
Largo, Fl. 33771
727-518-7294
727-584-4937
advancedpsychfl.com

CHILD HISTORY QUESTIONNAIRE

The following questions are being asked to help us better understand your child. Please fill out this questionnaire before your child is evaluated and bring it with you on the day of your appointment. Please read the questions carefully and answer them as fully as possible. Use the back of the page if necessary.

Are there parts of this questionnaire that should not be discussed in front of your child? ___ **Yes** ___ **No**

Date form was completed: _____

Person completing form: _____ Relationship to child: _____ Phone #: _____

CHILD'S INFORMATION:

Child's name: _____ Age: _____ Date of Birth: _____ Sex: M F Other
Last First

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: _____

* **IMPORTANT NOTE:** *Has this child been tested in the last 12 months (e.g., special education, intellectual, academic, speech/language, psychological, developmental)? If yes, please contact the clinic at the number above and ask to speak to the doctor who is scheduled to see your child.*

REFERRAL INFORMATION:

Please describe as fully as you can, why your child is being brought for evaluation. If he/she has had a medical condition that may be contributing to his/her problems (e.g., head injury, seizures, brain tumor), please include what happened, when, what treatment was provided, etc . . .

_____

_____

_____

FAMILY INFORMATION:

	Birth Mother	Birth Father
Name:	_____	_____
Age:	_____	_____
Highest grade completed:	_____	_____
Occupation:	_____	_____
Home Address:	_____	_____
Phone Number:	_____	_____

Status of **parents' relationship**: ____ Married ____ Separated ____ Divorced ____ Widowed ____ Single
How long married? _____ How long divorced? _____ Child's age at divorce: _____

If parents are separated or divorced, who has **custody** of this child? _____

How often does the **other parent** see this child?

___ Weekly or more often ___ Once or twice/month ___ Few times/yr. ___ Never

Is this child **adopted**? ___ Yes ___ No If yes, child's age at adoption _____

Does this child have **other parent(s)/stepparent(s)**? ____ Yes ____ No
If yes, please provide the following information:

	Adoptive Mother or Stepmother or Other (Circle One)	Adoptive Father or Stepfather or Other (Circle One)
Name:		
Age:		
Highest grade completed:		
Occupation:		
Home Address:		
Phone Number:		

This **child is living with**:

____ Both parents ____ Mother ____ Father ____ Mother and Stepfather ____ Father and Stepmother

____ Legal guardian ____ Other (please specify)_____

How long has this child been in current living situation? _____

Please list all of this child's siblings and their relationship to the child:

Child's Siblings Name	Age	Sex	Relationship Full	Half	Step	Resides in the home?
1._____	____	____	___	____	____	___ Yes ___No
2._____	____	____	___	____	____	___ Yes ___No
3._____	____	____	___	____	____	___ Yes ___No
4._____	____	____	___	____	____	___ Yes ___No
5._____	____	____	___	____	____	___ Yes ___No

Please list any **other persons** residing in the home:

Name	Relation to Child
1. _____	_____
2. _____	_____

Family Income:

( )$00,000 - $12,000 ( )$20,001 - $24,000 ( ) $33,001 - $37,000
( )$12,001 - $16,000 ( )$24,001 - $28,000 ( ) $37,001 - $41,000
( )$16,001 - $20,000 ( )$28,001 - $33,000 ( ) over $41,000

Please check the background of each of the following:

	Child	Mother	Father
Ethnicity			
1. Hispanic or Latino	( )	( )	( )
2. Not Hispanic or Latino	( )	( )	( )
3. Unknown	( )	( )	( )
Race			
a. African-American or Black	( )	( )	( )
b. Asian	( )	( )	( )
c. Caucasian or White	( )	( )	( )
d. Native American/Alaskan	( )	( )	( )
e. Native Hawaiian/Pacific Islander	( )	( )	( )
f. Other:_____	( )	( )	( )
f. Unknown	( )	( )	( )

Sometimes aspects of background or identity are important in understanding a child. By background or identity, we mean, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.

In your opinion, are there aspects of your child's **background or identity** that we should know? If yes, please describe these aspects and how it impacts your child's life:_____

_____

What is the **primary language** spoken in the home? ____ English ____Spanish Other:_____

Does the child speak a language other than English? ___ Yes ___No

If yes, what language(s)?_____ At what age did the child start speaking this language?_____

What do you **enjoy** most about this child? _____

What do you find most **difficult** about raising this child? _____

Who is mainly in charge of **discipline** in the home? _____

Do all caregivers agree on discipline? _____

Describe discipline techniques: _____

PREGNANCY AND DELIVERY

Mother's age at pregnancy of this child: _____ Father's age at pregnancy of this child: _____

When did prenatal care begin with this child? _____

Mother's **health during** the pregnancy: ____ Excellent ____ Fair ____ Poor

Please check any of the following that the child's mother had during the pregnancy of this child:

___ Measles
___ German measles
___ High fever
___ High blood pressure/toxemia
___ Diabetes
___ Excessive swelling
___ Excessive vomiting
___ Poor nutrition
___ Abnormal weight gain
___ X-rays (what month?) _____
___ Emotional problems
___ Injury/accident
___ Placenta abrupta
___ Placenta previa

___ **Hospitalizations/surgeries** If yes, please describe: _____

___ Took **medications during** pregnancy If yes, please describe _____

___ Other complications: Please describe_____

Substances used during pregnancy:

___Cigarettes: If yes, how many? _____ per (___day ___ week)

___Alcohol: If yes, how many drinks? _____ per (__ day ___ week ___ month)

___Drugs: If yes, please describe type(s) of drug, frequency of use, and when during pregnancy _____

_____

This child was born: ___ On time ___ Early ___ Late Length of pregnancy: _____ Weeks

Type of labor: ___ Spontaneous ___Induced Length of labor: _____ hours

Type of **delivery**: ___ Head first ___ Breech ___ C-section ___ Forceps/suction used

___ Cord around neck ___ Cord presented first ___ Hemorrhage ___ Infant injured during preg.

___Other (describe) _____

This child's **birth weight**: _____ Length of stay in hospital: Mother: _____ days

Child: _____ days

Check any of the following that the child had at birth or during the first week of life:

___ Difficulty breathing If yes, describe_____

___ Supplemental oxygen If yes, how long?_____

___ Seizures/convulsions ___Feeding problems ___Excess vomiting ___Fever

___ Jaundice ___Bilirubin lights used ___Drugs/medications needed

___ Other complications (describe): _____

DEVELOPMENTAL HISTORY

Are (or were there) any concerns about the development of this child? ____Yes ____ No

If yes, explain_____

Describe this child as an infant/toddler (check all that apply):

___ Active	___ Cuddly	___ Sickly	___Colic
___ Calm	___ Hard to please	___ Breathing problems	___ Slow to develop
___ Easy	___ Difficult	___ Frequent ear infections	___ Rocked self a lot
___ Happy	___ Cried frequently	___ Sleeping problems	___ Head banging

___ Poor eye contact ___ Other problems (specify):_____

Give approximate ages when the child did the following:

Gross Motor

Sat unsupported _____

Crawled/crept _____

Stood unassisted _____

Walked alone _____

Fine Motor

Picked up small objects _____

Fed themselves _____

Held a crayon _____

Language

Said "mama/dada" _____

Spoke first words _____

Talked in 2-3 word sentences _____

Talked in full sentences _____

Toileting

Bladder trained _____

Bowel trained _____

Has the child received any **intervention** services between the ages of 0-3 years?

Speech-language therapy? ____Yes ____ No

Occupational therapy? ____Yes ____ No

Physical therapy? ____Yes ____ No

SCHOOL HISTORY

Does or did this child attend **Preschool**? ____Yes ____ No If yes, at what age? _____

Amount of time per day: _____ hours _____ days/week

Any problems in Preschool? ____Yes ____ No If yes, please describe: _____

_____

Has this child received a **Child Find** evaluation? ____Yes ____ No If yes, what were the results?: _____

_____

Did the child receive **intervention services** in preschool? ____Yes ____ No If yes, please describe: _____

_____

Does or did this child attend **kindergarten**? ____Yes ____ No

Any problems in kindergarten? ____Yes ____ No If yes, please describe _____

_____

What **school** is the child attending?_____ Grade _____

Has this child ever **repeated** a grade? ____Yes ____ No If yes, which grade(s)_____

Has this child **skipped** a grade in school? ____Yes ____ No If yes, which grade(s) _____

Does or did this child have any difficulty with **math**? ___Yes ___ No If yes, explain: _____

_____

Does or did this child have any difficulty with **reading**? ___Yes ___ No If yes, explain:_____

_____

Does or did this child have any difficulty with **spelling/writing**? ___Yes ___ No If yes, explain:_____

_____

Has this child ever been **tested before** (e.g., special education, intellectual, academic, speech/language, psychological, developmental)? ___Yes ___ No If yes, explain: _____

_____

_____

Please circle if your child has ever received any of the following:

Student Assistance Team (SAT) to develop academic intervention **Current Past Never**

Individualized Education Plan (IEP) **Current Past Never** 504 Plan **Current Past Never**

If yes, what is (or what was) the primary disability (e.g., reason child is/was eligible)?

____ Specific Learning Disorder ____Intellectual Disability ____Traumatic Brain Injury

____ Speech or Language Impairment ____ Autism ____ Emotional Disturbance

____ Other Health Impairment

Please circle if your child has ever received any of the following **special education services**:

Speech-language therapy	**Current**	**Past**	**Never**	Social Work/counseling	**Current**	**Past**	**Never**
Occupational therapy	**Current**	**Past**	**Never**	Behavior Intervention Plan	**Current**	**Past**	**Never**
Physical therapy	**Current**	**Past**	**Never**	Other: _____	**Current**	**Past**	**Never**

If currently receiving special education, what is the setting for special education services?

____ Inclusion setting services only (i.e., all special education provided in regular education classroom)

____ Segregated services primarily (i.e., all academic coursework provided in segregated/special education classroom)

____ Mixed settings (i.e., some classes in regular education classroom and in segregated/special education classroom)

If mixed, Please list child's classes taught in Inclusion setting: _____

Please list child's classes taught in Segregated setting: _____

MEDICAL HISTORY

Please check any of the following that this child has had and indicate age (year/month)

_____ Measles	_____ Appetite/weight problems	_____ Fainting/dizziness
_____ Meningitis or encephalitis	_____ Sleep problems	_____ Anemia
_____ Seizures/convulsions	_____ Vision problems	_____ Poisoning
_____ Diabetes	_____ Hearing problems	_____ Persistent high fever
_____ Head injury/concussion	_____ Cardiac problems/hypertension	_____ Asthma
_____ Headaches/migraines	_____Chronic pain	

Please describe any **serious illness or operations**: Age

_____ _____

_____ _____

_____ _____

Current **medications**: Name Dose/Frequency Prescribed by

_____

_____

_____

_____

Are there any concerns with this child's **physical health**? ____Yes ____ No

If yes, please describe _____

Who is this child's primary care **physician**? _____

Has this child had a recent **vision** exam? ____Yes ____ No

Does this child wear corrective lenses? ____Yes ____ No

Has this child had a recent **hearing** check? ____Yes ____ No

Does this child wear hearing aids? ____Yes ____ No

Has this child ever had a **neurological exam**? ____Yes ____ No

If yes, neurologist's name: _____

Date of exam: _____ Reason for exam: _____

Results: _____

Has this child ever had an **EEG**? ____Yes ____ No

If yes, when, why, and what were the results? _____

Has this child ever had an **MRI** or **CT**? ____Yes ____ No

If yes, when, why and what were the results?_____

Cognitive/Behavioral/Social/Mental Health History

Please circle if your child **currently** and/or **in the past** has any of the following problems or difficulties:

Academic learning problems	**Current**	**Past**	Unusual beliefs/delusions	**Current**	**Past**
Difficulties learning life skills	**Current**	**Past**	Hallucinations	**Current**	**Past**
Slow mental processing	**Current**	**Past**	Hyperactivity	**Current**	**Past**
Short term memory	**Current**	**Past**	Short attention span	**Current**	**Past**
Long-term memory	**Current**	**Past**	Poor listening skills	**Current**	**Past**
Spatial awareness problems	**Current**	**Past**	Poor concentration	**Current**	**Past**
Gross motor coordination	**Current**	**Past**	Poor organization	**Current**	**Past**
Fine motor coordination	**Current**	**Past**	Distractibility	**Current**	**Past**
Bed wetting	**Current**	**Past**	Poor judgment	**Current**	**Past**
Soiling problems	**Current**	**Past**	Poor temper control	**Current**	**Past**
Poor peer relations	**Current**	**Past**	Poor impulse control	**Current**	**Past**
Prefers to play alone	**Current**	**Past**	Poor frustration tolerance	**Current**	**Past**
Prefers to play with younger children	**Current**	**Past**	Noncompliance	**Current**	**Past**
Repetitive behaviors/tics	**Current**	**Past**	Lying	**Current**	**Past**
Sensory processing difficulties	**Current**	**Past**	Excessive fighting	**Current**	**Past**
Anxiety/fears	**Current**	**Past**	Alcohol/drug abuse	**Current**	**Past**
Depression	**Current**	**Past**	Running away	**Current**	**Past**
Suicidal ideation	**Current**	**Past**	Difficulties with the law	**Current**	**Past**
Self-harm/cutting	**Current**	**Past**	Fire setting	**Current**	**Past**
Eating disorder	**Current**	**Past**	Truancy	**Current**	**Past**

What **activities** does this child enjoy (e.g., sports, hobbies, music, art)? _____

_____

Has this child ever been physically or sexually **abused** or **neglected**? ____Yes ____No If yes, please explain:

_____

Has this child ever been removed from the home because of **neglect or abuse**? ____Yes ____No If yes, please explain:

_____

Has this child had any unusual, **traumatic** or possibly **stressful events** that you think may have had an impact on his/her development and current functioning? If yes, please describe the incident. Include the child's age at the time of incident.

_____

_____

Has this child ever been in trouble with the **law**? ____Yes ____No If yes, please explain: _____

_____

Has this child ever received **mental health treatment**, such as counseling (either individually or with the family)?

____Yes ____ No If yes, please list any past or current treatments, name of counselor, and when this child was treated:

_____

_____

_____

FAMILY HISTORY

Please indicate if any members of this child's family have or have had any of the following (especially siblings, parents and grandparents):

	Relationship to this child
Alcoholism	_____
Anxiety/Phobias	_____
Attention deficit disorder/hyperactivity	_____
Autism Spectrum Disorder	_____
Bipolar Disorder (manic-depression)	_____
Cerebral palsy	_____
Depression	_____
Drug abuse	_____
Epilepsy (seizures, convulsions)	_____
Explosive temper	_____
Genetic Disorders	_____
Hospitalized for mental illness	_____
Language/Speech problem	_____
Learning problems/disorders	_____
Mental retardation	_____
Migraines	_____
Neurological conditions (such as stroke)	_____
Reading problem	_____
Schizophrenia	_____
Stuttering	_____
Suicide	_____
Tourette's syndrome	_____

Please indicate whether any of this child's immediate family members have/had have any other serious medical problems:

Medical Problem(s)	Family Member
_____	_____
_____	_____

Additional Information

Please add any additional comments you think might be helpful.

_____

_____

_____

_____