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By completing this questionnaire prior to our first appointment, you will be helping me to better understand your questions and the concerns that that may be affecting your child and your family. This information will also provide me with a great deal of important information that will allow us to work together most effectively. Please answer each of these questions as completely as possible.

Please return this information and all attached forms at least one week prior to our appointment so that I have the opportunity to preview it before your visit.

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Name of person completing form: _____

Relationship to child: _____

Date form completed: _____

****

Child's name:_____ Date of birth:_____ Gender: M/F

Address: _____ City: _____ Zip:_____

Home phone: _____ Cell phone: _____ E-mail: _____

Mother's name: _____ Date of birth: _____

Highest level of education completed: _____ Occupation: _____

Place of Employment: _____ Work hours: _____

Work phone: _____ Cell phone: _____ E-mail: _____

Father's name: _____ Date of birth: _____

Highest level of education completed: _____ Occupation: _____

Place of Employment: _____ Work hours: _____

Work phone: _____ Cell phone: _____ E-mail: _____

Step-mother's name (if applicable): _____ Date of birth: _____

Highest level of education completed: _____ Occupation: _____

Place of Employment: _____ Work hours: _____

Work phone: _____ Cell phone: _____ E-mail: _____

Step-father's name (if applicable): _____ Date of birth: _____

Highest level of education completed: _____ Occupation: _____

Place of Employment: _____ Work hours: _____

Work phone: _____ Cell phone: _____ E-mail_: _____

I. Purpose of visit:

Please describe the problems your child has been experiencing:

How have these problems been affecting your child's or your family's daily life?

When did these problems first begin?

Has your child previously received any type of evaluation or treatment for these issues? __ Yes __ No
If yes, **when** did this occur and with whom?

What type of services are you hoping to receive? (please check any/all that apply)

____ diagnosis
____ developmental/cognitive assessment
____ academic assessment
____ emotional/psychological assessment
____ individual psychotherapy
____ family therapy services
____ enhancement of parenting skills

II. Family History:

Parents are:
Married: ____ Date: _____
Separated: ____ Date: _____
Divorced: ____ Date: _____
Widowed: ____ Date: _____
Unmarried: ____

If parents are separated or divorced, who has legal custody?

If parents are separated or divorced, please describe physical custody and visitation arrangements:

Did the child experience changes in caretakers during the first 3 years of life? ___ Yes ___ No
If yes, please explain:

Please list <u>all</u> people who are *currently* living in the same home with the child:

Name	Gender	Age	Relationship to child

Is this child a foster child? __ Yes __ No Was this child adopted? __ Yes __ No

If a foster child or adopted, how long has this child been in your home? _____

If child was adopted, has this been discussed with the child? __ Yes __ No

How many times has your child moved or changed residence during the last 3 years? _____

Who provides care for your child while you are at work (if applicable)? _____

During the last 12 months, has your family experienced any of the following:

Death of a family member ____
Serious illness ____
Unemployment ____
Marital problems ____
Other (please describe) ____

Have any other family members had any medical problems or symptoms during the past 3 years (including headaches, back pain, stomach problems, problems with nerves, asthma or other breathing problems, diabetes, heart problems)? If yes, please list family members and the symptoms they experienced.

III. Medical history of the child's *biological* family:

Has anyone in the child's biological family ever experienced any of the following? Check all that apply.

	Birth Mother	Birth Father	Mother's Family	Father's Family	Siblings of patient
Alcoholism					
Birth defects					
Drug abuse					
Mental retardation					
Other developmental disabilities					
Learning disorders					
Attention Deficit/ADD/ADHD					
Seizures					
Headaches					
Neurologic disease					
Diabetes					
Heart disease					
Asthma					
Other lung/breathing problems					
Tics/Tourette's syndrome					
Genetic disorders					
Depression					
Suicide					
Anxiety problems					
Schizophrenia					
Hearing problems					
Vision problems					
Child abuse					
Sexual abuse					
Other _____					

IV. Substance use

Did the birth mother use any of the following substances during the pregnancy?

Type	Yes	No	Unknown	List Specific Substances	Which Trimester?
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Prescribed medication	___	___	_____	_____	_____
Other drugs (e.g. recreational)	___	___	_____	_____	_____

Does anyone in the family ***currently*** consume alcohol on a regular basis?

Child ___ Yes ___ No

Mother ___ Yes ___ No

Father ___ Yes ___ No

Siblings ___ Yes ___ No

Others (please describe) ___ Yes ___ No

Does anyone in the family ***currently*** use any street (recreational) drugs?

Child ___ Yes ___ No

Mother ___ Yes ___ No

Father ___ Yes ___ No

Siblings ___ Yes ___ No

Others (please describe) ___ Yes ___ No

V. Birth History:

This section should be completed by the child's birth mother, if possible.

Please indicate the following:

Number of pregnancies you have had: _____

Number of live births _____

Number of stillbirths _____

Number of miscarriages _____

Number of living children _____

Number of deceased children _____

This child was the product of which pregnancy? _____

Did you receive regular prenatal care during this pregnancy? ___ Yes ___ No

Did you experience any problems during this pregnancy? ___ Yes ___ No

If yes, please describe the difficulties you experienced (e.g., gestational diabetes, high blood pressure, weight loss, fevers, bleeding, excessive vomiting, accidents, etc.), as well as the point(s) in the pregnancy during which this occurred (e.g., which trimester?):

Did you carry this baby a full 9 months? ___ Yes ___ No
If no, please indicate the length of the pregnancy, in total number of weeks: _____

Were there any complications during the labor or delivery? ___ Yes ___ No
If yes, please describe (e.g., baby showed signs of distress, maternal difficulties, baby showed signs of heart or respiratory problems, cord around neck, emergency C-section, etc.):

How much did your baby weigh at birth? _____

Did your baby require any special care shortly after birth? ___ Yes ___ No
If yes, please describe the problems she/he experienced and the type of care (e.g., supplemental oxygen, ventilator support, incubator, medications, surgery, etc.):

VI. Medical History:

Who is your child's current physician?

Please list the physician's mailing address and phone number:
Address :

Phone:

How long has your child been seeing this doctor?

When was your child's last medical examination?

Please list your child's current: Height: _____ Weight: _____

When was your child's last vision exam?

When was your child's last hearing exam?

Is your child currently taking any medications? ___ Yes ___ No
If yes, please list **each** medication and the **reason** your child is taking each medication:

1)

2)

3)

4)

Has your child ever been hospitalized? ___ Yes ___ No
If yes, please list ages and reasons:

Has your child ever had surgery? ___ Yes ___ No
If yes, please list ages and reasons:

Has your child ever had any serious accidents? ___ Yes ___ No
If yes, please describe:

Has your child ever had a head injury? ___ Yes ___ No
If yes, was your child seen by a physician? ___ Yes ___ No
If yes, please list ages and describe what happened:

Does your child complain of frequent headaches ___ Yes ___ No

Does your child complain of frequent stomachaches? ___ Yes __ No

Do you have concerns about your child's eating habits? ___ Yes ___ No
If yes, please describe:

Do you have concerns about your child's sleeping habits/patterns? ___ Yes ___ No
If yes, please describe:

Has your child had any difficulties with bed wetting or soiling after age 5 ? ___ Yes ___ No

Has your child ever been physically abused? ___ Yes ___ No
If yes, has she/he received medical treatment? ___ Yes ___ No
If yes, has she/he received any psychological treatment? ___ Yes ___ No
If yes, were the police or Child Protective Services contacted? ___ Yes ___ No

Has your child ever been sexually abused? ___ Yes ___ No
If yes, has she/he received medical treatment? ___ Yes ___ No
If yes, has she/he received any psychological treatment? ___ Yes ___ No
If yes, were the police or Child Protective Services contacted? ___ Yes ___ No

Has your child ever observed *anyone else* being abused or assaulted? ___ Yes ___ No
If yes, please explain:

Has your child ever been evaluated for an attention disorder or hyperactivity (ADD or ADHD)?
___ Yes ___ No

If yes, **when** was the evaluation conducted?

Has your child ever been **diagnosed** with either ADD or ADHD? ___ Yes ___ No
If yes, who made this diagnosis?

Has your child ever been **treated** for ADD or ADHD? ___ Yes ___ No
If yes, what forms of treatment have been attempted?

VII. Developmental History:

At what age did your child begin to consistently demonstrate the following:

Sit up without help	_____	Clearly state single words *meaningfully*	_____
Crawl	_____	Combine 2 or more words	_____
Walk without help	_____	Speak in full sentences	_____

All parents observe and compare their child's growth and skill development to other children of similar ages. Please place a check mark next to any of the following items that you have been concerned about and that you believe to be beyond the worries typically experienced by other parents of same age children:

___ Learning to talk
___ Understanding others
___ Building with blocks, playing with puzzles, drawing pictures
___ Gross motor skills (e.g., walking, running, climbing, riding a bicycle)
___ Fine motor skills (e.g., fastening buttons, zipping, using utensils for eating)
___ Early school-related skills (e.g., naming colors, learning to count)
___ Sitting quietly for TV or listening to stories
___ Playing or socializing with other children
___ Eating/feeding habits
___ Memory skills
___ Ability to follow verbal directions
___ School behavior
___ School achievement
___ Problems concentrating or staying on task
___ Hyperactivity
___ Impulsiveness
___ Low tolerance for frustration
___ Excessive fear or worry
___ Ongoing sadness or depression
___ Response to limit-setting and discipline

VIII. School History:

What school does your child currently attend?

What grade is your child currently enrolled in? _____

Has your child ever repeated a grade? ___ Yes ___ No
If yes, what grade(s) was/were repeated? _____

How many schools (in total) has your child attended since beginning school? _____

Please list the schools your child has attended, along with the corresponding grade:

Grade(s)	School	Comments

Has your child ever received an intellectual or academic evaluation ("testing")? ___ Yes ___ No
If yes, **when** was this completed, and **by whom**?

Has your child ever received any of the following services?

___ Speech/language therapy
___ Physical therapy
___ Occupational therapy
___ Special Education services
___ Learning Resource Center
___ School counseling

IX. Social Experiences:

What are your child's favorite play or recreational activities?

Does your child prefer to occupy his/her free time alone, or with others (circle)? Alone With others

How many close friends does your child have (circle)? 0 1 2-3 4+

How many times per week does your child usually get together with them (circle)? 0 1 2-3 4+

Please describe how your child gets along with other children when socializing:

X. Mental Health Issues:

Has your child ever been evaluated by or been involved in treatment with another mental health professional? ___ Yes ___ No

If yes, please list each psychologist, psychiatrist, or counselor:

Type of professional: _____
Reason child was seen: _____
Age at time child was seen: _____
Length of time child/family worked with this professional: _____
If a formal diagnosis was given, please describe: _____
Was this a helpful experience? ___ Yes __ No
Type of professional: _____
Reason child was seen: _____
Age at time child was seen: _____

Length of time child/family worked with this professional: _____

If a formal diagnosis was given, please describe: _____

Was this a helpful experience? ___ Yes __ No

XI. Significant Events:

Has your child ever experienced any extended (longer than a few days) separations from his/her mother? ___ Yes ___ No

If yes, please describe circumstances, including child's age(s) at the time of separation(s):

Has your child ever experienced any extended (longer than a few day) separations from his/her father? ___ Yes ___ No

If yes, please describe circumstances, including child's age(s) at the time of separation(s):

Has your child ever experienced the loss or death of someone he/she was close to? ___ Yes ___ No

If yes, please describe:

Has your child ever experienced any frightening or traumatic events? ___ Yes ___ No

If yes, please describe:

XII. Strengths:

Please describe your child's strengths and positive qualities, in as much detail as you would like:

Thank you very much for completing this questionnaire. I realize that it is long and required a great deal of your time. Please be assured, however, that this will be extremely helpful in our work together. I look forward to seeing you for our first appointment.

Jeffrey Gillman, Ph.D.