Aspiring Families
Positive Tools for Thriving Families

CHILD HISTORY QUESTIONNAIRE

Today's Date: _____

Parent Information

Name: _____

Home Address: _____

City/State/Zip: _____

Home Phone: _____

Work Phone: _____

Date of Birth: _____

Employer: _____

Work Address:_____

City/State/Zip: _____

Name of Spouse/Partner: _____

Names of Legal/Custodial: _____

Parent/s_____

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Child Information

Name:

_____

Date of Birth: ____/____/_____

Address: _____
Street *Apt.*

_____
City *State* *Zip*

Mother's Name: _____ Age: ____

Occupation: _____

Father's Name: _____ Age: ____

Occupation: _____

Home Telephone: _____

Work/Day Phone: _____

Child's Legal

Guardian(s):_____

Emergency Contact

Name: _____

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Relationship to Child: _____

Tel #: _____

Primary Care Physician's Name: _____

Address: _____

Date of Last Physical: _____

Please list any current medical concerns: _____

Please list any medications child is taking, including dosages and frequency: _____

_____

Please list members of child's immediate family and other members of household: ____

_____

Parental Status

If partnered, for how long: _____ If married, on what date:_____

If separated or divorced, please give date(s) and explain the circumstances, custody & visitation schedule (if any) and communication status between parents. Additionally, please attach a copy of the custody order.

_____

_____

_____

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_____

_____

If a parent is deceased, please give the date and explain the circumstances:

_____

_____

_____

Developmental History

If adopted, please give any relevant information about biological parent history:

_____

_____

_____

(If adopted, please answer to the best of your knowledge)

Briefly describe your child:

_____

_____

_____

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Were there any illnesses/complications during pregnancy with this child?

_____

_____

_____

Total number of pregnancies: _____

Were there any miscarriages: _____ Please explain circumstance(s):

_____

_____

_____

Pregnancy was (circle one) Full Term Premature Late

If premature or late, number of weeks _____

Labor was (circle one) Less than 2 hours More than 24 hours 2 to 24 hours

Delivery was (circle one)

Normal Induced Breech Cesarean Section

Birth Weight _____

During pregnancy, did any of the following occur? If yes, please add additional detail, including when in pregnancy, frequency, names of medications, etc.

Bleeding Yes No _____

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High Blood Pressure	Yes	No	_____
Frequent Nausea or Vomiting	Yes	No	_____
Serious Illness or Injury	Yes	No	_____
Gestational Diabetes	Yes	No	_____
Use Alcohol	Yes	No	_____
Smoke Cigarettes	Yes	No	_____
Take Prescription Medications	Yes	No	_____
Use Drugs	Yes	No	_____

During delivery, did any of the following occur? If so, please specify

Fetal cardiopulmonary distress	Yes	No	_____
Cord wrapped around neck	Yes	No	_____
Need for oxygen	Yes	No	_____
Had difficulty breathing	Yes	No	_____
Infection	Yes	No	_____
Injury	Yes	No	_____
Early distress or birth defect	Yes	No	_____
Did baby leave hospital with mother?	Yes	No	_____

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Is there anything else of note regarding pregnancy or delivery?

_____

_____

Early Development

During the first year, was your child:

Please describe:

Alert	Yes	No	_____
Difficult to feed	Yes	No	_____
Difficult to get to sleep	Yes	No	_____
Difficult to put on a schedule	Yes	No	_____
Colicky	Yes	No	_____
Easy to soothe	Yes	No	_____
Cheerful	Yes	No	_____
Affectionate	Yes	No	_____
Sociable	Yes	No	_____
Active	Yes	No	_____

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Was there anything else notable about your child in the first years?

_____

_____

_____

_____

When did your child reach the following milestones?

Smiling	Early	Average	Late	_____
Sitting	Early	Average	Late	_____
Crawling	Early	Average	Late	_____
Walking	Early	Average	Late	_____
First words	Early	Average	Late	_____
First sentences	Early	Average	Late	_____
Toilet trained	Early	Average	Late	_____
Ride a bicycle	Early	Average	Late	_____
Drawing	Early	Average	Late	_____

Were there any other early milestones of note, either early or late?

_____

_____

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_____

_____

Medical History

Is child in generally good health? _____ If no, please describe: _____

_____

_____

Does your child have any current medical or genetic condition? If so, please describe:

_____

_____

Does your child have, or has your child ever had, any of the following? If so, please specify.

Vision problems	Never	Past	Current	_____
Hearing problems	Never	Past	Current	_____
Frequent ear infections	Never	Past	Current	_____
Head injury	Never	Past	Current	_____
High fevers	Never	Past	Current	_____

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Broken bones Never Past Current _____

Lead Poisoning Never Past Current _____

Seizures Never Past Current _____

Allergies Never Past Current _____

Asthma Never Past Current _____

Frequent headaches Never Past Current _____

Hospitalizations Never Past Current _____

Frequent falls or clumsiness Never Past Current _____

Frequent bruising Never Past Current _____

Heart or breathing difficulty Never Past Current _____

Surgery Never Past Current _____

Other serious illness or injury Never Past Current _____

Is your child currently under the care of a physician other than a pediatrician?

_____

_____

Has your child ever been referred to a medical specialist? If so, what specialty and why? _____

_____

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Please note any other health concerns, past or current. _____

_____

_____

Has your child ever had strong reactions to any of the following?

Tags on clothes, or seams on socks	Yes	No	_____
New clothing	Yes	No	_____
Tight clothing	Yes	No	_____
Hugging	Yes	No	_____
Touch	Yes	No	_____
Noises or sounds	Yes	No	_____
Smells	Yes	No	_____
Tastes or food textures	Yes	No	_____
Bright lights	Yes	No	_____

How well does your child manage transitions from one activity to another? _____

_____

_____

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How does your child react to changes in schedule or new situations?_____

_____

_____

Do you have any concerns or comments about your child's social interactions with peers? _____

_____

_____

Family History

Does anyone in the immediate or extended family have any of the following? If so, please explain:

Attention problems	Parent	Sibling	Extended Family_____
Learning problems	Parent	Sibling	Extended Family_____
Difficulty reading	Parent	Sibling	Extended Family_____
Difficulty with math	Parent	Sibling	Extended Family_____
Difficulty writing	Parent	Sibling	Extended Family_____
Seizure Disorder	Parent	Sibling	Extended Family_____
Depression	Parent	Sibling	Extended Family_____
Anxiety	Parent	Sibling	Extended Family_____

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Bipolar Disorder Parent Sibling Extended Family_____

Obsessive Compulsive Disorder Parent Sibling Extended Family_____

Other psychiatric disorder Parent Sibling Extended Family_____

_____

School History

Name of school: _____

_____

Grade: _____

Address of School: _____

Telephone Number _____

Name of Teacher or Contact: _____

Has child ever repeated a grade? _____ If so, which grade? _____

Reason for repeating grade: _____

Does your child receive any special help in school? _____ Is there an IEP? _____

504? _____

If child receives help, what kind?_____

_____

_____

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Has child ever had any psychological, educational or developmental evaluation in the past?____

If so, where was most recent testing?

_____

Please indicate whether your child:

Easily attends school	Yes	No	_____
Becomes anxious or sick before school	Yes	No	_____
Refuses to go to school	Yes	No	_____
Frequently visits nurse or counselor	Yes	No	_____
Has difficulty riding a school bus	Yes	No	_____
Has difficulty with a teacher	Yes	No	_____
Accuses peers of bullying	Yes	No	_____
Has been the target of a bully	Yes	No	_____
Fights with peers	Yes	No	_____
Is disrespectful to teachers	Yes	No	_____
Accuses teachers of picking on them	Yes	No	_____
Has difficulty reading	Yes	No	_____

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Has difficulty with math	Yes	No	_____
Has speech or language difficulties	Yes	No	_____
Has difficulty writing	Yes	No	_____
Has difficulty with fine motor tasks	Yes	No	_____
Has difficulty with attention	Yes	No	_____
Has difficulty remaining in a seat	Yes	No	_____
Has difficulty with homework	Yes	No	_____
Has difficulty with organization	Yes	No	_____

Behavioral and Emotional Functioning

Does your child currently have any behavior problems at home? If so, please explain:

_____

_____

_____

Does your child currently have any behavior problems at school? If so, please explain:

_____

_____

_____

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Does child have any emotional concerns, including depression or anxiety? If so, please explain: _____

_____

_____

Is child currently in psychotherapy or counseling? If so, please list issues currently being addressed in therapy:

_____

_____

Therapist's Name and Address:

_____

_____

_____

If child is under the care of a psychiatrist, please list psychiatrist's name and address:

_____

_____

_____

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Please list any life changes or stressors that your child has experienced. These may include moving to a new home, changing schools, physical or emotional abuse, death of a relative or other traumatic experience. Please indicate your child's age for each event.

_____

_____

_____

_____

_____

Are there any other emotional or behavioral concerns you have?

_____

_____

_____

Please indicate whether any of the following apply to your child:

Generally positive mood	No	Yes	Past	Current
Easygoing or easy to get along with	No	Yes	Past	Current
Social anxiety	No	Yes	Past	Current
Shyness	No	Yes	Past	Current

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Difficulty making/keeping friends	No	Yes	Past	Current
Interacts easily with peers	No	Yes	Past	Current
Has difficulty reading social cues	No	Yes	Past	Current
Frequently irritable	No	Yes	Past	Current
Sleep difficulties	No	Yes	Past	Current
Poor appetite	No	Yes	Past	Current
Overeats	No	Yes	Past	Current
Anorexia	No	Yes	Past	Current
Binge eating and/or purging	No	Yes	Past	Current
Expresses a wish to die	No	Yes	Past	Current
Self-injurious behaviors	No	Yes	Past	Current
Fears or phobias	No	Yes	Past	Current
Repeats one action/behavior	No	Yes	Past	Current
Obsessive interest in one subject	No	Yes	Past	Current
Cries easily	No	Yes	Past	Current
Mood swings	No	Yes	Past	Current
Easily angered	No	Yes	Past	Current
Bedwetting	No	Yes	Past	Current

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Toileting problems	No	Yes	Past	Current
Experienced physical abuse	No	Yes	Past	Current
Experienced sexual abuse	No	Yes	Past	Current
Witnessed domestic violence	No	Yes	Past	Current
Experienced emotional abuse	No	Yes	Past	Current
Risk taking behaviors	No	Yes	Past	Current
Suicide attempt	No	Yes	Past	Current
Plays with fire	No	Yes	Past	Current
Drug or alcohol use	No	Yes	Past	Current
Problems with law enforcement	No	Yes	Past	Current
Steals	No	Yes	Past	Current
Lies	No	Yes	Past	Current
Bullies others	No	Yes	Past	Current
Harms or is cruel to animals	No	Yes	Past	Current

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Psychological/Educational Assessment (Please complete if this applies to your child):

Please describe the concerns you have for yourself or your child. Also, please add any additional information that you think would be useful in this assessment:_____

_____

_____

_____

_____

What question(s) do you hope will be answered with this assessment?

_____

_____

_____

Your name: _____ Relation to child: _____

Date: _____

Signature: _____

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