

PERSONAL HISTORY QUESTIONNAIRE

Personal and Confidential

Child's Name: _____ D.O:B _____ Age _____
School: _____
Phone #s: () _____ Fax: _____
Principal: _____ Teacher: _____

Mother's name _____
Mother's place of birth _____
Father's name _____
Father's place of birth _____

Address: _____
Phones: _____
Email: _____

If there are questions that you are unable to answer, please leave them blank and we can discuss them during our interview. Please respond to questions by supplying a tick mark in the appropriate spot. In many cases you will be asked to explain or expand on your answer – please provide brief explanations where you can and we may expand on the question and answer in our interview. Feel free to elaborate in the margins if you wish.

Please be assured that all questions have relevance to academic functioning. There may be some questions in this questionnaire that you do not feel comfortable answering for personal reasons. If that is the case, do not feel obliged to answer them – just leave them blank. Personal information does not have to appear in your final report if it makes you feel uncomfortable.

Please note that this questionnaire may seem long but once you get going you will probably find that you are ticking off many simple questions rather quickly and it will not take as long as you first think? You are welcome to make a photocopy of this questionnaire for your own records and reference.

REFERRAL INFORMATION:

List the reason you are seeking psychological services for this child:

PARENTS AND FAMILY HISTORY:

Are both parents still living?

Yes ____ No ____

If either parent is deceased, please indicate who is deceased (mother or father) and how old you were when they deceased.

If both parents are still living, have they remained together or have they separated or divorced?

Still Together ____ Separated /(year) ____/____ Divorced/(year) ____/____

If they are separated or divorced, how did the ending of their relationship affect your child?

Not at all ____ Mildly ____ Moderate ____ Severe ____

Please explain:

What does, or did, the father do as an occupation during adulthood?

What does, or did, the mother do as an occupation during adulthood?

Do you have any other children?

Yes ____ No ____

If yes, please list them in terms of gender and their age in brackets.

Please indicate if any suffer from learning difficulties or are gifted.

Brother/Sister

Grade/College/University

Occupation

1)

2)

3)

4)

FAMILY HEALTH:

Have any family members had any of the following conditions?

- () Tourette’s syndrome
- () Birth defect
- () Heart disease
- () Physical handicap
- () Memory problems(dementia)
- () Alcohol/drug abuse
- () Behavior problems
- () Learning problems/school problems
- () Emotional problems/mental illness
- () others: _____

CHILD CARE:

Who provides care for this child in the absence of current caregivers? _____

How many hours per day? _____

How many different people care for this child and how does child relates to them? _____

How does this child relates to parents? Closer to one than the other?

PERSONAL HISTORY

Early Developmental

Where was your child born?

Were there any complications during the pregnancy? (toxemia, alcohol, stress etc.)

Yes ____ No ____ Don’t Know _____

If yes, what were they?

Were there any complications during the delivery or as a newborn? (premature, low birth weight, lack of oxygen, etc.)

Yes ____ No ____ Don't Know ____

If yes, what were they?

Were there any recent changes or factors (e.g. relocation, separation, illness) that have affected your family?

Psychologists use the term "Childhood Developmental Milestones". This term refers to the normal age ranges when babies, toddlers and children learn to do things. As far as you know, were there any difficulties learning to (if yes please provide a tick **mark** – if **no leave empty**):

crawl ____ walk ____ talk ____ toilet training ____ wetting the bed ____

fine motor control ____ kicking or catching a ball ____ tying shoe laces ____

riding a bicycle ____ learning to tell left from right ____ learning directions ____

general clumsiness ____ poor hand-eye coordination/clumsiness ____

Other: _____

Did your child experience any of the following challenges as a **preschooler**:

Hyperactivity ____ Distractibility ____ Irritability ____ Temper Tantrums ____

Withdrawal ____ Shy ____ Fearful ____ Do Not Know ____ Other ____

Defiance ____ Other _____

Difficulty separating from you: _____

Describe your child as a toddler:

What was the dominant language spoken in your home between birth and Kindergarten?

Were any other languages spoken in the home during school-age years?

What is the child's dominant language now?

Have you ever being concerned with your child speech? If yes please explain:

Which is their dominant hand?

Right ____ Left ____ Ambidextrous ____

Social Development

During childhood, did your child have any difficulty fitting in socially with the other children?

Yes ____ No ____ Some ____

If yes, please describe them and how did this affect him/her?

How would you describe your child's social network?

Alone a lot ____ Ignored by others ____ Harassed ____

A few acquaintances ____ Many acquaintances ____

One close friend ____ Several close friends ____ Many close friends ____

Prefers to play with younger/older children; _____

When playing with his friends what role does your child occupy?leader?follower?

How would you describe your child's temperament?(self-control, short-attention span,hides feelings, cries a lot for no apparent reason, anger, meeting new people,etc)

Is your child involved in any organized extra curricular activities or had any hobbies? (I.e. sports ... the arts ... etc.)

Yes ____ No ____

If yes, what are they and during what ages or did he/she participate?

Does your child present with any management difficulties at home or at school (i.e. self-directed, needs reminding, avoids)? Please elaborate.

What method have you found most effective in dealing with this issue?

Medical History

As a child or since, has your child had any of the following medical problems? Please indicate by writing **Y** for yes, **N** for no, and **M** for maybe in the first spot, the ages when they were affected in the second spot and any treatment (s) that they had in the third spot. If you do not know any answers, either provide a good estimate or write **DK** for don't know).

Frequent Ear Infections ____ Ages _____ Treatment _____

Allergies ____ Ages _____ Treatment _____

Asthma ____ Ages _____ Treatment _____

Frequent colds/flu/s/infections ____ Ages _____ Treatment _____

Serious Fevers ____ Ages _____ Treatment _____

Headaches ____ Ages _____ Treatment _____

Stomach/Bowel Problems ____ Ages _____ Treatment _____

Has your child had any other medical or health problems in the past or at this time?

Yes ____ No ____

If yes, please describe the condition (s) and any treatments that they had?

Has your child ever been hospitalized or had any surgeries?

Yes ____ No ____

If yes please list them:

Problem	Age/Grade	Length of Stay	Days Missed at School
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- 1)
- 2)
- 3)
- 4)

Are they currently taking any medications?

Yes _____ No _____

If yes, please indicate what the medication is for, and what it is called.

Does your child have vision problems?

Yes _____ No _____ Don't Know _____

If yes, do they wear glasses and have they adequately corrected their vision? (Tick two if applicable)

Yes _____ No _____ Do not Know _____

Does your child have hearing problems?

Yes _____ No _____ Don't Know _____

If yes, please provide details and history.

Has your child ever sustained an injury to their head where they lost consciousness?

Yes _____ No _____ Don't Know _____

Health Indicators & Lifestyle

Is your child involved in physical exercise?

Not at all _____ Occasionally _____ Regularly _____

How would you describe their appetite?

Poor _____ Fair _____ Good _____

How would describe the quality of their diet?

Poor ____ Fair ____ Good (Healthy) ____

Does your child have difficulty falling asleep?

Not at all ____ Occasionally ____ Usually ____ All the time ____

Does your child have difficulty staying asleep?

Not at all ____ Occasionally ____ Usually ____ All the time ____

How many hours of sleep are they averaging per night? _____

Is this enough? _____

Do they wake up feeling restored or re-energized?

Not at all ____ Occasionally ____ Usually ____ All the time ____

Does your child suffer from fatigue?

Not at all ____ Occasionally ____ Usually ____ All the time ____

Psychological Development

Has your child ever been assessed by your family doctor, pediatrician, psychiatrist or psychologist for any behavioural-emotional or psychological problem?

Yes ____ No ____ Don't Know ____

Were they diagnosed with any condition?

Yes ____ No ____ Don't Know ____

If yes, what was/were the conditions and when were they diagnosed?

Has your child ever taken any medications for any behavioural-emotional problems?

Yes ____ No ____

Are they currently taking any medications for behavioural emotional concerns?

Yes ____ No ____

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

Who is in charge of the disciplining in the home?

Do all caregivers agree on discipline?

Have any of these problems interfered with school/home life in the past?

Yes ___ No ___ Don't Know ___ Not Applicable ___

EDUCATIONAL HISTORY

Elementary and Middle School(Kindergarten through Grade 8)

Please list the different school your child has attended.

<u>School</u>	<u>Grades Attended</u>	Standing	Days per week
1.			
2.			
3.			
4.			
5.			
6.			

How did your child behave when he/she started school: _____

(Elementary/high school)

Did your child changed schools for any other reason than normal academic progression?

Why? _____

Has been retained or skipped a grade? _____

Any difficulties with:

Reading: _____

Math: _____

Gets poor grades: _____

Is your child receiving extra help at school? Special education services?

Tutoring? _____ for what subject? _____ how many hours _____

Has an Individual education Plan being developed for your child? Ever? _____

Yes ____ No ____ Don't Know ____

If yes, please explain: _____

ADDITIONAL COMMENTS:

Thanks for completing this questionnaire,

Valda Lopo, C. Psychologist
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