Child/Adolescent History Questionnaire

This questionnaire is to be completed at home and then brought with you to the office of John Largen & Associates at the time of your child's appointment. Questions? Call 281-957-9863

HISTORY OF CHILD or ADOLESCENT:

First: who is filling out this form? What is your relationship to the child?

Child's Name:

Child's Date of Birth: Age: Sex: M F Race: (Circle) Left or Right Handed?

Parent(s) Name(s):

Is your child bilingual? yes no If yes, what is his/her preferred language?

Is your child adopted? yes no

Are the biological parents (circle): Married Separated Divorced Widowed Never Married

If divorced, have the biological parents remarried? yes no If yes, who remarried and for how long?

Please list everyone living at home with the child, their ages, and relationships to the child:

Are there any other brothers or sisters who do not live at home? yes no
If so what are their names and ages:

Mother's health (please circle): Excellent Fair Poor
Father's health (please circle): Excellent Fair Poor

Do any of the brothers or sisters have medical, educational, or psychological problems? yes no If yes, please explain:

What are the parent's occupations: Mother:
Father:
Step-parent:

***PROBLEMS AND SYMPTOMS**:*

What is your understanding of why your child has been referred to us for testing?
Please give details about the nature of the problem:

-How are these problems affecting your child's life, school, and relationships?

What circumstances or factors do you think worsen these problems?

Do both parents agree about the nature and causes of the problem? yes no If no, please explain:

-When did these problems start and is there any known cause?

-Are these problems getting better or worse or is there no change over time?

EDUCATIONAL HISTORY:

Child's Grade: Name of School:

Private or Public School: School District:

Please circle if your child has ever been diagnosed with any of the following: -Dyslexia

-Learning Disability

-ADD or ADHD (Attention Deficit Disorder)

What age or grade was your child diagnosed with his/her problem?

Has your child repeated any grades? yes no If yes, what grade(s) and why:

Please circle if your child has even been enrolled in: -Special Education -Content Mastery -Tutoring
If so, please give details about what grades and subjects:

In school, is your child currently having difficulty with: Reading? Spelling? Writing? Math?

What have been your child's typical grades this year: (circle) A-B B-C C-D D-F

What were his/her grades in the last several years?

If there has been a significant change in grades over time? If yes, is there anything known to account for this change?

If your child is having academic problems, what do his/her teachers believe to be the problem?

What are your child's strengths in school?

Weaknesses in school?

Are there other problem areas in school that have not been addressed in this questionnaire? If so, please give details:

BIRTH HISTORY:

Were there any complications or heath problems of the mother's during pregnancy? yes no
If yes, please give details:

Were there any complications at birth (cord around neck, meconium inhalation, difficulty breathing, blue baby)? yes no
If yes, please give details:

Was the delivery by Cesarean-section? yes no Birth weight if known?

Was the birth: (circle) On-time Premature Late If premature or late, by how many weeks?

After birth, was their any special care, treatment, or equipment that the child required? yes no If yes, please explain:

DEVELOPMENTAL HISTORY:

In terms of developmental milestones, was your child slow, on-time, or early for motor development (sitting, crawling, walking)?

Are there any current motor difficulties (clumsiness or awkward compared to siblings and friends in terms of running, skipping, climbing, biking, playing ball)? yes no *If yes, please give details:*

Was your child slow, on-time, or early for language development?

Are there any current speech or language difficulties (stuttering, difficult to understand)? yes no
If yes, please give details:

Has your child ever had speech or language therapy? yes no
If yes, please give details:

MEDICAL HISTORY:

Has your child had any surgery? yes no
If yes, please list what type of surgery and when?

Other than surgery, has your child ever been hospitalized overnight for illness or injury? yes no
If yes, please give details about reasons and ages.

Does your child have any visual problems? Any hearing problems?

Please list your child's current medications and dosages.

Please circle if your child has had any of the following medical problems:

Neurological Conditions:

-Head Injury (includes concussion, loss of consciousness)

-Epilepsy or seizures

-Staring spells (petit mal seizures)

-Febrile seizures (fever related)

-Brain infection (encephalitis or meningitis)

-Any loss of oxygen for a long time

-Other neurological condition not listed (specify):

-Brain tumor

-Tourette's Syndrome or tic disorder

-Hydrocephalus

-Episodes of passing out or fainting

-Paralysis or weakness on any part of the body

-Headaches (migraine, tension headaches)

Chronic Pain

-Juvenile Arthritis

-Chronic pain of other cause (specify)

Other Medical Problems

-Juvenile Diabetes

-Cancer

-Heart Problems

-Gastrointestinal problems

-Kidney disease or renal disease

-Allergies requiring medication (what kind of allergies?)

-Other medical problems not listed here (specify):

-Thyroid problems (hypothyroidism, hyperthyroidism, goiter)

-Blood Disorders (sickle cell, anemia, hemophilia)

-Asthma

-Eating problems (including anorexia, bulimia)

-Liver or hepatic disease

-Juvenile Arthritis or other pain syndrome

PSYCHOLOGICAL AND EMOTIONAL HISTORY:

Is your child **currently** having behavioral or emotional problems in school? yes no If yes, please give details:

If your child **currently** having behavior or emotional problems at home? yes no If yes, please give details:

Is your child **currently** seeing a psychiatrist, psychologist, psychotherapist, or counselor? Circle: yes no

In the past, has your child seen a psychiatrist, psychologist, psychotherapist, or counselor? Circle: yes no

Has your child ever been hospitalized for a psychiatric or emotional problem? Circle: yes no

If applicable, what medications has your child been prescribed for psychological or emotional difficulty?

Please circle if your child has been diagnosed with any of the following currently or in the past:

-Depression
-Bipolar Disorder (manic depressive disorder)
-Anxiety
-Phobias
-Obsessive Compulsive Disorder
-Other?
-Psychosis or Schizophrenia
-Autism
-Asperger's Disorder
-Oppositional Defiant Disorder
-Substance or Alcohol Use/Abuse

SOCIAL BEHAVIOR:

Does your child get along well with other children? yes no Get along with adults? yes no
If not, please explain:

Is your child able to make and keep friends adequately? yes no If no, please explain:

Does your child understand social cues (e.g., knows when others are angry)? yes no

DRUG/ALCOHOL HISTORY:

Is there any known alcohol or drug use: yes no
If yes, please give any details:

LEGAL HISTORY: Has your child had any legal problems? If yes, please explain:

FAMILY PSYCHIATRIC HISTORY:

Do any of the child's parents, siblings or other close relatives have psychological or psychiatric problems? yes no
If yes, relationship, types of problems)?