KASEY SERDAR, PH.D.
LICENSED PSYCHOLOGIST

The purpose of this questionnaire is to obtain background data concerning your child. By completing this confidential form as fully as possible, you are assisting our staff with this evaluation and reducing the time required to meet with you to obtain this information. We appreciate your cooperation and patience.

Date: ________________

Child's Name: ____ Birthdate _______________ Age: _______

Address:____

City: _____________________________________ State: __________________________ Zip: _____________

How long at this address? ______________________________ Birthplace: ____________________________

Person completing this form: ____________________________ Relation to child: _______________________

REFERRAL INFORMATION:

Who referred you to this office, or how did you find out about us?

Name: ____ Phone number: _________________________

Address: ____

PRIMARY CONCERNS:

Please describe the problem(s) or concerns for which you are seeking help at this time:

____

____

____

____

____

When did the problem(s) first appear or begin? ____

Whom else have you consulted about your child's problem(s)? ____

What procedures have you tried on your own? ____

PRIOR TREATMENT

Has your child ever received inpatient or outpatient treatment or other services for this or other/related problems? Yes _____ No______

If yes, please list person(s) providing treatment in order, including names, addresses and phone numbers.

NAME	DATE	ADDRESS	PHONE #

PRIOR TESTING

Has your child received prior psychological testing? Yes _____ No______ Please bring or list results.

MEDICATION HISTORY

Has your child ever taken psychiatric medications? Yes _____ No______ If yes, please list.
Is your child on any other regular medications now? Please list.

	Drug Name	Drug Name	Drug Name	Drug Name
Prescribed by whom				
Date started/ended				
For what problems?				
Dose				
Benefits				
Side Effects				
Results				

PREGNANCY

While you were pregnant with this child, were you under a doctor's care? Yes _____ No______

Mother's age at time of birth? ________ years Father's age at time of birth? ________ years

Did mother smoke during pregnancy? Yes _____ No______ Drink alcohol? Yes _____ No______

Was this a planned pregnancy? Yes _____ No______ Which pregnancy for mother? (1st, 2nd, etc?) _____

Check all that apply for this pregnancy:

		Describe
________	Anemia	________________________
________	Elevated blood pressure	________________________
________	Toxemia	________________________
________	Swollen ankles	________________________
________	Kidney disease	________________________
________	Bleeding	________________________
________	Measles	________________________
________	German Measles	________________________
________	Flu	________________________
________	Strep Throat	________________________
________	Other virus	________________________
________	Other illness	________________________
________	Nausea or vomiting	________________________
________	Injury	________________________
________	Take medication(s)	________________________
________	Threatened miscarriage	________________________
________	Premature labor	________________________
________	Severe emotional distress	________________________
________	Abnormal weight gain (excessive or minimal	________________________
________	Gestational diabetes	________________________

BIRTH HISTORY (Labor and Delivery)

How many hours from first contractions to birth? ______________________________

What did the baby weigh? ________ lbs. _________ oz.

Was the mother given medication? Yes _____ No______

If yes, what type? __________________________

Was the mother under anesthesia during childbirth? Yes _____ No______ Don't know _______

If yes: local _____ spinal _____ general _____

Was labor induced? Yes _____ No______

Was labor planned? Yes _____ No______

Was this a breech (feet first) delivery? Yes _____ No______

Was this delivery unusual in any way? Yes _____ No______

If yes, how? ____

Did you have a caesarean? Yes _____ No______

If yes, describe any complications ____

Was this a multiple (twins, triplets, etc.) birth? Yes _____ No______

If yes, which was born first? ____

Did this baby have: breathing problems? Yes _____ No______ Don't know ________
cord around neck? Yes _____ No______ Don't know _______

Did this baby cry quickly? Yes _____ No______ Don't know _______

Was this baby's color normal? Yes _____ No______ Don't know _______
Blue_____ Yellow_____

Was oxygen used for this baby? Yes _____ No______ Don't know _______
If yes, how long? ____

What was the baby's "APGAR" scores? ____

Was the baby premature? Yes _____ No______ How much? ___________________

Did you take the baby home with you from the hospital? Yes _____ No______ How long after? _______
If no, please explain why the child remained in the hospital: ____________________

____

Did you have any problems with feeding? Yes _____ No______

If yes, describe ____

Was the baby normally active? Yes _____ No______

DEVELOPMENTAL HISTORY:

At what age did child:

Sit alone	______	Say first word	______
Walk alone	______	Use two words together	______
Ride a tricycle	______	Become toilet trained:	
Dress self	______	--For day	______
Learn basic colors	______	--For night	______

Compared to other children, did or does your child have difficulty with:

Learning to talk	Yes _____ No______
Understanding language	Yes _____ No______
Gross motor skills (walking, hopping, riding)	Yes _____ No______
Fine motor skills (drawing, buttoning, typing)	Yes _____ No______
Early school-related skills (naming colors, alphabet, recognizing coins)	Yes _____ No______
Sitting still for stories or TV	Yes _____ No______
Playing/socializing with other children	Yes _____ No______
Building with blocks, doing puzzles, etc.	Yes _____ No______
Separating from parent(s)	Yes _____ No______
Sleeping	Yes _____ No______
Eating	Yes _____ No______
Showing a clear hand preference	Yes _____ No______

(Which hand is preferred? ________________)

If you responded yes to any of the above, please describe: ____

____

____

____

MEDICAL HISTORY

Who is your child's pediatrician? ____

Has your child had any of the following? (check all that apply)

_____ Measles

_____ German Measles

_____ Mumps

_____ Chicken Pox

_____ Whooping Cough

_____ Diphtheria

_____ Flu

_____ Meningitis

_____ Encephalitis

_____ High fever

_____ Ear Infections

_____ Tubes in ears

_____ Allergy/Asthma

_____ Convulsions/Seizures

_____ Head injuries/Loss of consciousness

_____ Other injuries

_____ Other illnesses

_____ Problems with hearing

_____ Problems with vision

_____ Hospitalization

TEMPERAMENT: (Check all that apply)

Shy or timid	_______	Fearful	_______	Impulsive	_______	Rocking	_______
Stubborn	_______	Cautious	_______	Poor sleep	_______	Headbanging	_______
Affectionate	_______	Underactive	_______	Curious	_______	Into everything	_______
Temper outbursts	_______	Overactive	_______	Easy to manage	_______	Slow to warm up	_______
Dare devil	_______	Happy	_______	Aggressive	_______	Poor eating	_______
Blank spells	_______	Falling Spells	_______	Tore up toys more than normal			_______
Wanted to be left alone			_______	More interested in things than people			_______

If you responded yes to any of the above, please describe: ____

____

____

Does your child play with (please circle all that apply):

Older children　　Younger children　　Same-age children

Has your child had any psychotherapy or counseling? Yes _____ No______

If yes, when? ____

With whom? ______________________________________

Outcome? ____

What problems does the child have at home? ____

____

When are these problems worse? ____

When are these problems better? ____

What important things have happened to child or family in the last 6 months? (e.g., death of a relative, divorce, family crisis, etc.)? ____

____

Describe child's strengths: ____

____

Describe child's weaknesses: ____

____

What people does child feel close to? ____

Any sudden changes in child's mood or behaviors? If yes, explain: ______________________

____

Which child is easiest to get along with? ______________________________________

Why? ____

Which child is the most difficult? ____

Why? ____

FAMILY INFORMATION:

Father's name: ___________________ Age: _______ Education: ___________________

Employment: _______________________________ Work phone: __________________

Type of work: ______________________________ Home phone: __________________

Mother's name: ___________________ Age: _______ Education: ___________________

Employment: _______________________________ Work phone: __________________

Type of work: ______________________________ Home phone: __________________

Other children in the home:

Name and age: _________________________ Name and age: _________________________

Name and age: _________________________ Name and age: _________________________

Name and age: _________________________ Name and age: _________________________

Other relatives or persons living in the home: __________________________________

____

Siblings/half-siblings NOT living in the home: __________________________________

____

Is your child adopted? Yes _____ No______

If yes, please describe the circumstances of the adoption: ____

____

____

How long married ?______________ If divorced, date of divorce: __________________________

If separated, date of separation: ____________________ If unmarried, how long cohabitating? ____________

Any previous marriages? Describe: ____

____

FAMILY PSYCHIATRIC HISTORY:

Has the child's FATHER or FATHER'S relatives had similar or other psychiatric problems; for example mood problems, seizures/epilepsy, other neurological disease or disorder, learning problems, ADHD?

Yes________ No ________ If yes, please describe including treatment:________________________________

____

____

Has the child's MOTHER or MOTHER'S relatives had similar or other psychiatric problems; for example mood problems, seizures/epilepsy, other neurological disease or disorder, learning problems, ADHD?

Yes________ No ________ If yes, please describe including treatment:________________________________

____

____

Does the child's BROTHER(S) or SISTER(S) have any psychiatric problems?

Yes________ No ________ If yes, please describe including treatment:________________________________

____

____

FAMILY MEDICAL HISTORY:

Is there any family history of medical illnesses (e.g., seizures, thyroid problems, allergies)? ____ Yes ____ No

If yes, please describe: ____

____

____

____

SCHOOL INFORMATION:

Name of school: ____ Phone #: ________________________

Teacher's name: _______________________________________ Grade: ___________________________

Type of school: Public: _______ Private: _______ Special: ________

List previous schools, dates attended and indicate overall performance, academic and behavioral:

School: ____ Dates: _________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

School: ____ Dates: _________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

School: ____ Dates: _________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

School: ____ Dates: _________________

Performance: Academic: Poor ____ Fair ____ Good ____ Behavioral: Poor ____ Fair ____ Good ____

Grades repeated ___________ Grades skipped __________ Expelled? Yes _____ No _______ # of times _____

Any known learning disabilities? If yes, explain: ____

____

____

Is your child in any special programs (speech, reading, etc.) Give names of tutors if relevant. If yes, explain:

____

____

How does the school describe your child's CLASSROOM behavior?: ________________________________

____

____

What does your child do best in at school? ____

____

____

Which of the following problems, if any, does your child have in school?

- ______ Does not do homework
- ______ Fails to check homework
- ______ Poor handwriting
- ______ Poor reading skills
- ______ Incomplete classroom work
- ______ Does not remain seated
- ______ Noncompliant in class
- ______ Problems with written language
- ______ Poor math skills
- ______ Starts but does not finish homework
- ______ Makes many careless errors
- ______ Poor spelling
- ______ Forgets assignments
- ______ Excessive time to complete assignments
- ______ Poor attention in class
- ______ Talks out inappropriately in class
- ______ Messy and disorganized

Describe any other problems around homework or academic functioning: ______________________________

____

Interactions with peers: _____ no friends _____ few friends _____ loses friends
_____ trouble making friends _____ mean, aggressive _____ too shy, timid
_____ bossy, controlling _____ plays well with peers

Further comments on peer relationships: ____

____

ADDITIONAL INFORMATION:

Is there anything else you feel we should know about your child? ____________________________________

____

____

____

Signature: _______________________________________ Date: ______________________________