MEREDITH HICKORY, PSY.D.

1020 SOUTHHILL DRIVE SUITE 300

CARY, NC 27513 TELE: 919 971.1495.

Pediatric Background Questionnaire

Confidential

The following is a detailed questionnaire on your child's development, medical history, and current functioning at home and at school. This information will be integrated with the testing results in order to provide a better picture of your child's abilities as well as any problem areas. Please fill out this questionnaire as completely as you can. Please print clearly.

CHILD'S FAMILY

Child's Name: _____ Today's Date:_____ Right orLeft handed:_____

Birth date: _____ Age: _____ Grade: _____ Name of School: _____

Name of person who recommended this evaluation: _____ Phone #: _____

Person filling out this form: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Other:

Address: _____City_____ State:____ Zip:_____Home phone #: _____Work #: _____

Biological Mother's Name: _____ Age: _____ Highest Grade Completed: _____

Number of Years of Education: _____ Degree/Diploma (if applicable): _____

Occupation: _____# hours a week: _____

Biological Father's Name: _____ Age: _____ Highest Grade Completed: _____

Number of Years of Education: _____ Degree/Diploma (if applicable): _____

Occupation: _____# hours a week: _____

Marital status of biological parents: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other: _____

If biological parents are separated or divorced:

How old was this child when the separation occurred? _____

Who has legal custody of the child? (Check one) ❑ Mother ❑ Father ❑ Joint/Both ❑ Other: _____

Stepparent's Name: _____ Age: _____ Occupation: _____

If this child is not living with <u>either</u> biological parent:

Reason: _____

❑ Adoptive parents ❑ Foster parents ❑ Other family members ❑ Group home ❑ Other: _____

Name(s) of legal guardian(s): _____

List all people currently living in your child's household:

Name	*Relationship to Child*	*Age*

If any brothers or sisters are living outside the home, list their names and ages:

_____

_____

Primary language spoken in the home: _____Other languages spoken in the home: _____

If your child's first language is not English, please complete the following:

Child's first language: _____ Age at which your child learned English: _____

BEHAVIOR CHECKLIST

Place a check mark (√) next to behaviors that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

Sleeping and Eating
- ❑ Nightmares
- ❑ Sleepwalking
- ❑ Trouble sleeping (describe): _____ _____
- ❑ Eats poorly
- ❑ Picky eater
- ❑ Eats excessively

Social Development
- ❑ Prefers to be alone
- ❑ Shy or timid
- ❑ More interested in objects than in people
- ❑ Difficulty making friends
- ❑ Plays or socializes with younger children
- ❑ Teased by other children
- ❑ Bullies other children
- ❑ Does not seek friendships with peers
- ❑ Not sought our for friendship by peers
- ❑ Does not play or socialize with other children outside of school
- ❑ Difficulty seeing another person's point of view
- ❑ Doesn't empathize with others
- ❑ Overly trusting of others
- ❑ Easily taken advantage of
- ❑ Overly familiar with people
- ❑ Difficulty understanding humor
- ❑ Overly attached to certain people

Behavior
- ❑ Stubborn
- ❑ Irritable
- ❑ Frequent tantrums
- ❑ Strikes out at others
- ❑ Throws things at others
- ❑ Destroys things
- ❑ Angry or resentful
- ❑ Oppositional
- ❑ Negativistic
- ❑ Lying
- ❑ Argues with adults
- ❑ Low frustration threshold
- ❑ Blames others for own mistakes
- ❑ Daredevil behavior
- ❑ Runs away
- ❑ Needs a lot of supervision
- ❑ Impulsive (does things without thinking)
- ❑ Talks excessively
- ❑ Skips school
- ❑ Interrupts frequently
- ❑ Poor sense of danger
- ❑ Purposely harms or injures self
- ❑ Dangerous to self or others (e.g., running into street) describe: _____ _____
- ❑ Talks about hurting self (describe): _____ _____
- ❑ Unusual fears, habits, repetitive behaviors, or mannerisms (describe): _____ _____
- ❑ Steals
- ❑ Depressed
- ❑ Cries frequently
- ❑ Excessively worried and anxious
- ❑ Overly preoccupied with details
- ❑ Overly attached to certain objects
- ❑ Not affected by praise
- ❑ Not affected by negative consequences
- ❑ Drug abuse
- ❑ Alcohol abuse
- ❑ Sexually active

Other Problems
- ❑ Wets bed
- ❑ Wets self during the day
- ❑ Poor bowel control (soils self)
- ❑ Motor/Vocal tics
- ❑ Overreacts to noises
- ❑ Overreacts to touch
- ❑ Fails to react to loud noise
- ❑ Poor sense of danger
- ❑ Has blank spells
- ❑ Sloppy table manners
- ❑ Bangs head
- ❑ Bites nails
- ❑ Picks nose
- ❑ Sucks thumb
- ❑ Masturbation in public places
- ❑ Excessive daydreaming and fantasy life

Motor Skills
- ❑ Poor fine motor coordination
- ❑ Poor gross motor coordination
- ❑ Clumsy
- ❑ Cannot tie shoes
- ❑ Cannot dress self
- ❑ Difficulty walking
- ❑ Difficulty running
- ❑ Cannot throw or catch

EDUCATION PROGRAM

Name of your child's primary teacher: _____ Phone: _____

Does your child have an individual education plan (IEP) or modified learning program? ❑ Yes (date of last update_____) ❑No

If yes, are you satisfied with the IEP? ❑ Yes ❑No

If not satisfied, please explain: _____

_____

Has your child ever repeated a grade? ❑ Yes ❑No

If yes, what grade(s) and why? _____

_____

Is your child's curriculum modified? ❑ Yes ❑No

If yes, please describe: _____

_____

Is your child in any special education classes? ❑ Yes ❑No

If yes, please describe: _____

_____

Is your child receiving assistance at school? ❑ Yes ❑No

If yes, please describe: _____

_____

Has your child been suspended or expelled from school? ❑ Yes ❑No

If yes, please describe: _____

_____

Has your child ever received tutoring outside of school? ❑ Yes ❑No

If yes, please describe: _____

_____

Rate your child's academic performance relative to other children of the same age. Please estimate the grade level your child is functioning at in the given area if he or she is above or below average.

	Above Average	Average	Below Average	Impaired	Grade Level
Handwriting	❑	❑	❑	❑	_____
Spelling	❑	❑	❑	❑	_____
Punctuation	❑	❑	❑	❑	_____
Vocabulary	❑	❑	❑	❑	_____
Reading speed	❑	❑	❑	❑	_____
Reading comprehension	❑	❑	❑	❑	_____
Math skills	❑	❑	❑	❑	_____

Check any problems reported from school:

- ❑ Difficulty sustaining attention
- ❑ Easily distracted
- ❑ Daydreaming
- ❑ Fidgeting / restless
- ❑ Frequently gets out of seat
- ❑ Difficulty working quietly
- ❑ Difficulty working independently
- ❑ Doesn't want to be called on
- ❑ Blurts out answers
- ❑ Difficulty following instructions
- ❑ Doesn't cooperate well in group activities
- ❑ Doesn't respect the rights of others
- ❑ Shifts from one activity to another
- ❑ Does better in a one-to-one relationship
- ❑ Won't wait his/her turn
- ❑ Teased by other children
- ❑ Talking back
- ❑ Refusing to do work
- ❑ Bullies other children
- ❑ Fighting
- ❑ Messy / disorganized
- ❑ Does not like school
- ❑ Truant
- ❑ Excessively tired or sleepy

Describe briefly other classroom or school problems if applicable: _____

_____

_____

COGNITIVE SKILLS

Rate your child's cognitive skills relative to other children of the same age.

	Above Average	Average	Below Average	Impaired
Speech	❑	❑	❑	❑
Comprehension of speech	❑	❑	❑	❑
Problem solving	❑	❑	❑	❑
Attention span	❑	❑	❑	❑
Memory for events	❑	❑	❑	❑
Organizational skills	❑	❑	❑	❑
Memory for facts	❑	❑	❑	❑
Learning from experience	❑	❑	❑	❑
Conceptual thinking	❑	❑	❑	❑
Overall Intelligence	❑	❑	❑	❑

Check any specific problems:

- ❑ Poor articulation/pronunciation
- ❑ Difficulty finding words to express self
- ❑ Disorganized speech
- ❑ Talks too loudly or softly
- ❑ Talks like a younger child
- ❑ Forgets to do things
- ❑ Easily distracted
- ❑ Frequently forgets instructions
- ❑ Frequently loses belongings
- ❑ Difficulty planning tasks
- ❑ Doesn't foresee consequences of actions
- ❑ Slow thinking

Describe briefly any other cognitive problems that your child may have: _____

_____

_____

Describe any special skills or abilities that your child may have: _____

_____

_____

DEVELOPMENTAL HISTORY

If your child is adopted, please fill in as much of the following information as you are aware of.

During pregnancy, did the mother of this child:

Take any medication? ❑ Yes ❑ No

If yes, what kind? _____

Smoke? ❑ Yes ❑ No

If yes, how many cigarettes each day? _____

Drink alcoholic beverages? ❑ Yes ❑ No

If yes, what kind? _____

Approximately how much alcohol was consumed each day? _____

Use drugs? ❑ Yes ❑ No

If yes, what kind? _____

How often were drugs used? _____

List any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc.): _____

_____

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____ Apgars (if known): _____ / _____

Were there any indications of fetal distress: ❑ Yes ❑ No

If yes on any of other above, for what reason? _____

_____

Check any that apply to the birth: ❑ Labor induced ❑ Forceps ❑ Breech ❑ Caesarean

If yes on any of other above, for what reason? _____

_____

What was your child's birth weight? _____

Check any that apply following birth: ❑ Jaundice ❑ Breathing problems ❑ Incubator ❑ Birth defect

If yes, please describe: _____

_____

_____

Were there any other complications? ❑ Yes ❑ No

If yes, please describe: _____

_____

Was there any maternal depression during the immediate post-natal period?

If yes, please describe: _____

_____

What was your first impression of your baby? _____

Were there any feeding problems? ❑ Yes ❑ No

If yes, please describe: _____

_____

Were there any sleeping problems? ❑ Yes ❑ No

If yes, please describe: _____

_____

Were there any growth or development problems during the first few years of life? ❑ Yes ❑ No

If yes, please describe: _____

_____

Were any of the following present (to a significant degree) during infancy or the first few years of life?

- ❑ Unusually quiet or inactive
- ❑ Did not like to be held or cuddled
- ❑ Not alert
- ❑ Difficult to soothe
- ❑ Colic
- ❑ Excessive restlessness
- ❑ Excessive sleep
- ❑ Diminished sleep
- ❑ Head banging
- ❑ Constantly into everything
- ❑ Excessive number of accidents compared to other children

Please indicate the approximate age in months or years at which your child showed the following behaviors. If you feel that you child was early or late in showing a listed behavior, please indicate by checking the appropriate box. Check never if your child has never shown the listed behavior.

	Age	Early	Late	Never		Age	Early	Late	Never
Smiled	_____	❑	❑	❑	Tied shoelaces	_____	❑	❑	❑
Rolled over	_____	❑	❑	❑	Dressed self	_____	❑	❑	❑
Sat alone	_____	❑	❑	❑	Fed self	_____	❑	❑	❑
Crawled	_____	❑	❑	❑	Bladder trained, day	_____	❑	❑	❑
Walked	_____	❑	❑	❑	Bladder trained, night	_____	❑	❑	❑
Ran	_____	❑	❑	❑	Bowel trained	_____	❑	❑	❑
Babbled	_____	❑	❑	❑	Rode tricycle	_____	❑	❑	❑
First word	_____	❑	❑	❑	Rode bicycle	_____	❑	❑	❑
Sentences	_____	❑	❑	❑					

CURRENT MEDICATIONS

List ***all*** medications that your child is currently taking:

Medication	*Reason Taken*	*Dosage (If known)*	*Start Date*

MEDICAL HISTORY

Name of pediatrician: _____ Date of last hearing examination: _____

Pediatrician phone #: _____ Date of last vision examination: _____

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date of the illness (if you prefer, you can simply indicate the child's age at illness).

Illness or condition	Date(s) or age(s)	Illness or condition	Date(s) or age(s)
❑ Measles		❑ Ear infection	
❑ German measles		❑ Dizziness	
❑ Mumps		❑ Severe headaches	
❑ Chicken pox		❑ Rheumatic fever	
❑ Whooping cough		❑ Tuberculosis	
❑ Diphtheria		❑ Bone or joint disease	
❑ Scarlet fever		❑ Sexually transmitted disease	
❑ Meningitis		❑ Anemia	
❑ Pneumonia		❑ Jaundice/hepatitis	
❑ Encephalitis		❑ Diabetes	
❑ High fever		❑ Cancer	
❑ Seizures		❑ High blood pressure	
❑ Allergy		❑ Heart disease	
❑ Hay fever		❑ Asthma	
❑ Injuries to head		❑ Bleeding problems	
❑ Broken bones		❑ Eczema or hives	
❑ Hospitalizations		❑ Suicide attempt	
❑ Operations		❑ Alcohol abuse	
❑ Otitis media		❑ Drug abuse	
❑ Visual problems		❑ Physical abuse	
❑ Fainting spells		❑ Sexual abuse	
❑ Loss of consciousness		❑ Paralysis	
❑ Poisoning		❑ Stomach pumped	

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the immediate family (i.e., brothers, sisters, aunts, uncles, cousins, grandparents) has had. Please note the family member's relationship to the child.

Condition	Relationship to child		Relationship to child
❑ Seizures or Epilepsy	_____	❑ Neurological illness or disease	_____
❑ Attention deficit	_____	❑ Mental illness	_____
❑ Hyperactivity	_____	❑ Depression or anxiety	_____
❑ Learning disabilities	_____	❑ Tics or Tourette's syndrome	_____
❑ Mental retardation	_____	❑ Alcohol or drug abuse	_____
❑ Childhood behavior problems	_____	❑ Suicide attempt	_____

Does your child wear glasses? ❑ Yes ❑ No

If yes, please list prescription or describe (e.g., nearsighted): _____

Does your child have a hearing problem? ❑ Yes ❑ No

If yes, please describe): _____

Does your child use a hearing aid? ❑ Yes ❑ No

List had any previous assessments that your child has had:

	Dates of Testing	Name of Examiner
Psychiatric	_____	_____
	_____	_____
Psychological	_____	_____
	_____	_____
Neuropsychological	_____	_____
	_____	_____
Educational	_____	_____
	_____	_____
Speech Pathology	_____	_____
	_____	_____

Have there been any recent stressors that you think may be contributing to your child's difficulties (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses)?_____

_____

_____

_____

_____

List any form of psychological/psychiatric treatment that your child has had (e.g., psychotherapy, family therapy, inpatient or residential treatment):

Type of Treatment	Dates	Name of Therapist

OTHER INFORMATION

What are your child's favorite activities: _____

_____

List any special interests that your child has: _____

_____

List any sports your child plays: _____

Has your child ever been in trouble with the law? ❑ Yes ❑ No

If yes, please describe briefly: _____

_____

_____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use.

- ❑ Ignore problem behavior
- ❑ Scold child
- ❑ Take away some activity or food
- ❑ Threaten child
- ❑ Reason with child
- ❑ Redirect child's interest
- ❑ Don't use any technique
- ❑ Tell child to sit on chair
- ❑ Send child to his/her room
- ❑ Spank child

Which disciplinary techniques are usually effective, and with what types of problem(s)? _____

_____

Which disciplinary techniques are usually ineffective, and with what types of problems? _____

_____

On the average, what percentage of the time does your child comply with requests or commands? _____

_____

What have you found to be the most satisfactory ways of helping your child? _____

_____

What are your child's assets or strengths? _____

_____

Is there any other information that you think that may help me in assessing your child? You may also use the back of this page.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of person completing this form: _____ Date: _____

Thank you for filling out this questionnaire.