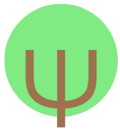

Hill Psychological Services

**Child Background Questionnaire**

Child's name: ____________________

Birth Date: __________ Age: ______ Gender (circle one): M / F

Home Address: ____________________ Phone: ______

____________________

School: ____________________ Grade: ______

Person filling out this form (circle one): Mother / Father / Stepmother / Stepfather/

Other (please explain) ____________________

**Main Email:** ____________________

Mother's name: ____________________

Occupation: ____________________ Phone:(h)______ (w) ______

Father's name: ____________________

Occupation: ____________________ Phone:(h)______ (w) ______

Marital status of parents: ____________________

**If separated or divorced, what are the custody arrangements?**

If separated or divorced, how old was child when this occurred? ______

Is your child adopted?______ If yes, when did adoption occur**?**__________

List all people living in household:

| Name | Age | Relationship to Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

If any siblings are living outside the home, list gender and ages:

____________________

Primary language spoken in the home: ____________________

Other languages spoken in the home: ____________________

Is there a family history or learning difficulties/disabilities, behavioural and/or mental health issues? If yes, please

describe:

During pregnancy, was mother on medication? Yes _______No _______

If yes, what kind? ________________________________________________

During pregnancy, did mother drink alcoholic beverages? Yes _______No _______

Approximately how much alcohol was consumed each day? ______________________

During pregnancy, did mother use drugs? Yes _______No _______

If yes, what kind? ________________________________________________

Was the child premature? Yes _______No _______

If so, by how many months? ____________________________________________

What was the child's birth weight? ______________________________________

Were they any birth defects or complications? Yes _______No _______

If yes, please describe: ______________________________________________

Were there any feeding problems? Yes _______No _______

If yes, please describe: ______________________________________________

Were there any sleeping problems? Yes _______No _______

If yes, please describe: ______________________________________________

As an infant, was the child quiet? Yes _______No _______

As an infant, did the child like to be held? Yes _______No _______

As an infant, was the child alert? Yes _______No _______

Were there any special problems in the growth and development of the child during the first few years? Please describe.

*The following is a list of infant and preschool behaviours. Please indicate the age at which your child first demonstrated each behaviour. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behaviour occurred, please write a question mark.*

| *Behaviour* | *Age* | *Behaviour* | *Age* |
|---|---|---|---|
| Showed response to mother | _____ | Put several words together | _____ |
| Rolled over | _____ | Dressed self | _____ |
| Sat alone | _____ | Became toilet trained | _____ |
| Crawled | _____ | Stayed dry at night | _____ |
| Walked alone | _____ | Fed self | _____ |
| Babbled | _____ | Rode tricycle | _____ |
| Spoke first word | _____ | | |

**CHILD'S MEDICAL HISTORY**

Please list any serious illnesses or medical conditions that your child has or has had. When you list an item, also note the approximate date (or age) of the illness and previous or current medications.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Last Vision Exam:__________________________ Result: _____________________________________________

Last Hearing Exam: ________________________ Result: ______________________________________________

**EDUCATIONAL HISTORY**

School History (Please List and continue on reverse side if necessary)

| **Year** | **Grade** | **School** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please place a check next to any educational difficulties that your child currently exhibits.

_____Has difficulty with reading

_____Has difficulty with arithmetic

_____Has difficulty with spelling

_____Has difficulty with writing

_____Has difficulty with other subjects

______________________________________

_____Does not like school

Is your child in an alternate education class or receiving accommodations or modifications?

If yes, what type of class/modifications?

Has your child ever received previous cognitive, academic or behavioural assessment and/or diagnosis?

If yes, when, by whom and results:

**SOCIAL AND BEHAVIOUR CHECKLIST**

Place a check next to any behaviour or problem that your child currently exhibits.

____Has difficulty with speech
____Has difficulty with hearing
____Has difficulty with language
____Has difficulty with vision
____Has difficulty with coordination
____Prefers to be alone
____Does not get along well with siblings
____Is aggressive
____Is shy or timid
____Is more interested in things (objects) than in people
____Engages in behaviour that could be dangerous to self or others (describe)

______________________________

____Has special fears, habits or mannerisms (describe)

______________________________

____Wets bed

____Has frequent tantrums
____Has frequent nightmares
____Has trouble sleeping (describe)

______________________________

____Eats poorly
____Is stubborn
____Has poor bowel control (soils self)
____Is much too active
____Is clumsy
____Has blank spells
____Is impulsive
____Shows daredevil behaviour
____Is slow to learn
____Gives up easily
____Is anxious/worries
____Other(describe)____________________

**PRESENTING DIFFICULTIES**

Briefly describe your child's current difficulties:

______________________________
______________________________
______________________________
______________________________
______________________________

How long has this problem been of concern to you? ____________________

When was the problem first noticed? ____________________

What seems to help the problem? ____________________

What seems to make the problem worse? ____________________

Has your child received evaluation or treatment for the current problem or similar difficulties?

Yes _______ No _______

If yes, when and with whom? ____________________

Is your child on any medication at this time? Yes _______ No _______

If yes, please note kind of medication: ____________________

By whom were you referred?

____________________

**What questions would you like answered by this assessment?**

____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________

**ADDITIONAL INFORMATION**

What are your child's favourite activities?

____________________

____________________

____________________

____________________

What activities does your child like least:

____________________

____________________

____________________

____________________

____________________

What disciplinary techniques do you usually use when your child behaves inappropriately?

____________________

____________________

____________________

____________________

What are your child's assets or strengths?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
________________________________________________________________

Is there any other information that you think may help us in working with your child?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
________________________________________________________________

Signature(s):

______________________________________________________________________
______________________________________________________________________
_________________________________________________________________

Date: ___________________________________________________

Please return this form at your **earliest** convenience to Lynde Hill, M.Sc., Registered Psychologist #3151