Neurobehavior Services, Inc. **Email: Admin@NeurobehaviorServices.com**

Janiece Turnbull, PhD & Associates
Clinical Neuropsychology, Pediatric & Adult
Consultation, Assessment, & Treatment
www.NeurobehaviorServices.com

685 East California Boulevard
Pasadena, CA 91106
Voicemail: 626.577.7744
Fax: 888.220.2463

Background Questionnaire

Confidential (For Report Purposes Only)

Thank you for filling out this questionnaire. Know that this information is very important to the assessment, so please be comprehensive and provide as much detail as possible.

Today's Date: _____

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

1. CONTACT AND DEMOGRAPHIC INFORMATION

Child's name: _____ Child's Birthdate: _____

Age: _____ Grade: _____ Sex (circle one): Male Female

Home address: _____

_____

Best Email: _____ Best Phone: _____ Work/Cell/Home

Parent's name: _____ Relationship to Child: _____ Age: _____

Highest grade completed / Degree(s): _____ Occupation: _____ PT/FT/OT: _____

Phone: Home _____ Business _____ Cell _____

Parent's name: _____ Relationship to Child: _____ Age: _____

Highest grade completed / Degree(s): _____ Occupation: _____ PT/FT/OT: _____

Phone: Home _____ Business _____ Cell _____

Parent's name: _____ Relationship to Child: _____ Age: _____

Highest grade completed / Degree(s): _____ Occupation: _____ PT/FT/OT: _____

Phone: Home _____ Business _____ Cell _____

List all people living / working in household (including parents, children, housekeepers/nannies):

Name	Relationship to Child	Age

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

Name	Relationship to Child	Age

Primary language spoken in the home: _____

Other languages spoken in the home: _____ By whom: _____

Ethnicity / Race: _____ Religion: _____

2. PRESENTING SITUATION

Who referred you for an evaluation? _____

What is this person's professional role or relationship to you? _____

Why did this person refer you for an evaluation? _____

_____

_____

_____

What are your primary concerns about your child? _____

_____

_____

_____

_____

_____

_____

_____

When were these difficulties first noticed by you? _____

_____

What information would you like this assessment to provide? What questions do you hope to have answered by this evaluation? _____

_____

_____

_____

_____

_____

Please describe your child's strengths. (Academically, socially, behaviorally, hobbies, etc.) _____

_____

_____

_____

_____

_____

_____

What are your child's favorite activities? _____

_____

_____

What activities would your child like to engage in more than he/she does at present? _____

_____

_____

What activities does your child like the least? _____

_____

3. SOCIAL AND BEHAVIOR CHECKLIST

Place a check in the right hand column next to any behavior or problem that your child currently exhibits. For any item that your child has exhibited in the past but is no longer a problem, please place a check in the left column.

Prior	Current	
☐	☐	Poor conversational skills
☐	☐	Needs repetition
☐	☐	Cannot follow commands with more than two steps
☐	☐	Difficulty understanding words
☐	☐	Difficulty understanding sentences
☐	☐	Seems to misunderstand others
☐	☐	Has difficulty producing speech
☐	☐	Speaks in monotone (very little emotion in speech)
☐	☐	Has difficulty with articulation
☐	☐	Constantly substitutes one sound for another Describe: _____
☐	☐	Has difficulty organizing sounds
☐	☐	Repeats sounds or syllables
☐	☐	Interjects sounds or words into speech
☐	☐	Prolongs words or sounds
☐	☐	Has broken words (e.g. pauses within a word)
☐	☐	Difficulty finding words
☐	☐	Limited vocabulary
☐	☐	Uses vague language (that, thing, etc.)
☐	☐	Makes errors in word structure, such as tense, plurals, pronouns, etc.
☐	☐	Difficulty organizing phrases and sentences
☐	☐	Abandons phrases and sentences
☐	☐	"Re-works" phrases and sentences
☐	☐	Difficulty producing (complex) sentences
☐	☐	Has difficulty expressing self with language
☐	☐	Has difficulty with hearing
☐	☐	Has difficulty with vision
☐	☐	Often has to be touching or leaning against something
☐	☐	Dislikes riding in cars / Easily carsick
☐	☐	Avoids / Dislikes playground equipment
☐	☐	Dislikes rides at amusement parks (e.g. roller coasters, spinning, etc.)

Overly sensitive or under-responsive to any of the following: *For each one checked, please indicate if over (o) or under (u) sensitive and provide examples:*

Prior	Current	
☐	☐	Touch ___ o ___ u: _____
☐	☐	Tactile texture (e.g. clothing, blankets) ___ o ___ u: _____
☐	☐	Having hair brushed ___ o ___ u
☐	☐	Brushing teeth ___ o ___ u: _____
☐	☐	Taking a bath / shower ___ o ___ u:

Prior	Current	
☐	☐	Temperature ___ o ___ u: _____
☐	☐	Movement ___ o ___ u: _____
☐	☐	Pain ___ o ___ u: _____
☐	☐	Light ___ o ___ u: _____
☐	☐	Noise ___ o ___ u: _____
☐	☐	Smell ___ o ___ u: _____
☐	☐	Taste/texture ___ o ___ u: _____
☐	☐	Eats poorly
☐	☐	Eating habits are poor or unusual
☐	☐	Has difficulty with fine coordination (e.g. picking up small items, etc.)
☐	☐	Has difficulty with gross motor coordination
☐	☐	Has difficulty with balance
☐	☐	Motor / Vocal tics Explain: _____
☐	☐	Oral (mouth) motor problems
☐	☐	Wets bed How often: _____
☐	☐	Has poor bowel control (soils self) If yes, how often? _____ Only at night? _____
☐	☐	Is clumsy (bumps, near-trips, etc.)
☐	☐	Drops things
☐	☐	Poor handwriting
☐	☐	Poor performance in sports
☐	☐	Not well coordinated in walking or moving
☐	☐	Accidentally falls off chairs or other furniture
☐	☐	Does things slower than other children
☐	☐	Prefers to be alone
☐	☐	Prefers to play alone
☐	☐	Does not get along well with brothers and sisters
☐	☐	Lack of make-believe play
☐	☐	Excessive make-believe play
☐	☐	Lack of age appropriate peer relationships
☐	☐	Imitates peers, or moves alongside peers, without actually "joining" in interactive play
☐	☐	Does not show much affection
☐	☐	Does not appear to form an emotional bond or connection with others
☐	☐	More interested in things (objects) than in people
☐	☐	Preoccupied with parts of objects
☐	☐	Shows no particular or special interest in people
☐	☐	Does not share interests or excitement with others
☐	☐	Poor eye contact
☐	☐	Lack of facial expression
☐	☐	Lack of interpersonal reciprocity (give and take in conversation)
☐	☐	Lack of social reciprocity (give and take in groups)

Prior	Current
☐	☐ Lack of emotional reciprocity (give and take in affect and emotion)
☐	☐ Lack of social gestures (acknowledging, waving, smiling, etc.)
☐	☐ Odd movements (posturing, peculiar hand movements, etc.)
☐	☐ Hand flapping
☐	☐ Hand wringing
☐	☐ Idiosyncratic language
☐	☐ Poor or unusual body postures
☐	☐ Self mutilates
☐	☐ Self-stimulates at home
☐	☐ Self-stimulates in public places
☐	☐ Rocks back and forth
☐	☐ Repetitive verbal or motor behaviors
☐	☐ Holds breath
☐	☐ Bangs head
☐	☐ A "different" child
☐	☐ Does not like change in routines
☐	☐ Makes comments that are completely unrelated to context
☐	☐ Has frequent tantrums or temper outbursts

How often? _____

How long do they last on average? _____

What triggers it? _____

☐	☐ Has frequent nightmares
☐	☐ Has night terrors
☐	☐ Mood changes quickly and drastically
☐	☐ Feels sad
☐	☐ Cries a lot
☐	☐ Irritable
☐	☐ Not interested in most activities
☐	☐ Not gaining expected weight
☐	☐ Lacks energy
☐	☐ Seems tired all the time
☐	☐ Expresses feelings of worthlessness
☐	☐ Seems unable to concentrate due to sad mood
☐	☐ Indecisive
☐	☐ Expresses thoughts about death
☐	☐ Expresses thoughts about hurting self
☐	☐ Has some type of disturbance with sleep:
	☐ Can't fall asleep
	☐ Stays up too late
	☐ Wakes up during the night
	☐ Wakes up too early
	☐ Sleepwalking
	☐ Nightmares
	☐ Other: _____
☐	☐ Is shy or timid

Prior	Current
☐	☐ Has worries
☐	☐ Has fears (describe): _____
☐	☐ Has habits or mannerisms that appear anxious (describe) _____ _____
☐	☐ Bites nails
☐	☐ Sucks thumb
☐	☐ Low frustration threshold
☐	☐ Often touchy or easily annoyed by others
☐	☐ Clingy with parents or caretakers
☐	☐ Has blank spells, stares off
☐	☐ Is slow to learn
☐	☐ Gives up easily with challenge
☐	☐ Daydreams
☐	☐ Poor attention span
☐	☐ Often loses things, then asks where things are
☐	☐ Doesn't seem to listen
☐	☐ Doesn't learn from experience
☐	☐ Poor memory / Forgets things
☐	☐ Messy or Disorganized
☐	☐ Engages in behavior that could be dangerous to self or others (describe) _____ _____
☐	☐ Is much too active, hyperactivity
☐	☐ Acts like he or she is driven by a motor
☐	☐ Wears out shoes more frequently than other siblings
☐	☐ Heedless to danger
☐	☐ Often engages in physically dangerous activities, shows daredevil behavior
☐	☐ Difficulty playing quietly
☐	☐ More active than siblings
☐	☐ Is impulsive in behavior, reacts too quickly
☐	☐ Acts before thinking
☐	☐ Poor self control
☐	☐ Is impulsive in talking, interrupts frequently
☐	☐ Often talks excessively
☐	☐ Sloppy table manners
☐	☐ Seems immature for age
☐	☐ Social skills are poor
☐	☐ Blames others for own mistakes
☐	☐ Is often angry or resentful
☐	☐ Often argues with adults
☐	☐ Stealing
☐	☐ Lying
☐	☐ Sudden outbursts, verbal or physical abuse of other children
☐	☐ Is stubborn
☐	☐ Is aggressive
☐	☐ Has negativistic and independent behavior
☐	☐ Erroneous / false beliefs

Prior	Current	Prior	Current
☐	☐ Unusual interpretations / perceptions of experiences Describe: _____	☐	☐ Hearing something that is not there (e.g. voices) Describe: _____
☐	☐ Has sensory experiences that are not real: Describe: _____	☐	☐ Seeing something that is not there Describe: _____
		☐	☐ Other: _____

How would you rate your child's overall level of intelligence compared to other children the same age?
☐ Below Average ☐ Average ☐ Above Average

How would you rate your child's overall level of academic performance compared to other children the same age?
☐ Below Average ☐ Average ☐ Above Average

How would you rate your child's level/degree of behavior problems compared to other children the same age?
☐ Less than Average ☐ Average ☐ More than Average

How would you rate your child's overall social skills compared to other children the same age?
☐ Below Average ☐ Average ☐ Above Average

How would you rate your child's overall level of emotional/psychological adjustment compared to other children the same age?
☐ Below Average ☐ Average ☐ Above Average

4. EDUCATION AND SCHOOL HISTORY

Present School: _____
Street: _____
City, State Zip: _____
School District: _____
Type of School: ☐ Public ☐ Private ☐ Parochial ☐ Other: _____

My child likes school: ☐ All or most of the time ☐ Sometimes ☐ Almost never

My child's current grades are (choose the appropriate system): ☐ ungraded class

☐ A&B ☐ B&C ☐ C&D ☐ D&F
☐ Outstanding ☐ Good ☐ Satisfactory ☐ Improvement Needed ☐ Unsatisfactory
☐ 90's ☐ 80's ☐ 70's ☐ 60's ☐ Below 60

Compared to previous years, my child's grades have: ☐ Stayed the same ☐ Improved ☐ Declined

To what degree do the following impact your child's performance and/or engagement in school:

Structured vs. Unstructured Classroom: _____
Structured vs. Unstructured Teacher: _____
Class size: _____
Relationship to teacher: _____
Interest in the subject: _____

The child's best subject(s): _____
The child's hardest subject(s): _____

Place a check next to any educational problem 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
(please list) _____

Favorite, disliked, and difficult subjects in the past: _____
_____
_____

Do teachers report any of the following behaviors at school?

- ☐ Doesn't respect authority
- ☐ Social or peer difficulties
- ☐ Anger or aggressiveness
- ☐ Atypical or unusual behaviors
- ☐ Easily distracted
- ☐ Frequently gets up and walks around the classroom
- ☐ Shouts out
- ☐ Doesn't cooperate well in group activities
- ☐ Shifts from one activity to another
- ☐ Doesn't respect the rights of others
- ☐ Doesn't pay attention during storytelling or show and tell
- ☐ Doesn't sit still in his/her seat
- ☐ Doesn't want to be called on
- ☐ Difficulty following instructions
- ☐ Won't wait his/her turn
- ☐ Difficulty sustaining attention
- ☐ Typically does better in a one to one relationship
- ☐ Is teased / bullied
- ☐ Meanness or teasing others

<u>School History</u>

Age began school: _____

Names of Schools

Preschool: _____ Hours per day / Days per week: _____
Preschool: _____ Hours per day / Days per week: _____
School: _____ Grade level: _____
School: _____ Grade level: _____
School: _____ Grade level: _____

Has your child ever had an IEP? (Please be sure to provide copies of these records.)

☐ Yes ☐ No

a. If so, when was the initial meeting? (Approximate date o.k.) _____
b. When were the following IEPs? _____

Child has been in the following classes:

- ☐ Resource room
- ☐ LD class (full time)
- ☐ LD class (part time)
- ☐ Emotional/Behavior problems
- ☐ Advanced Instruction
- ☐ Other: _____

Has your child ever repeated or skipped a grade? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever been expelled from school? ☐ Yes ☐ No

Has a school ever threatened to expel your child, or was your child asked to leave or change schools because of behavior? ☐ Yes ☐ No

In school, my child:

☐ Gets along well with other children / has friends OR ☐ Does not get along with other children
☐ Gets along well with the teacher(s) OR ☐ Does not get along with the teacher(s)

5. EVALUATIONS AND SERVICES

Previous Evaluations

Check any tests or evaluations that have been conducted with your child.

	Date: (approx. o.k.)	Results (your best recall is fine):
☐ Occupational therapy evaluation	/ /	_____
☐ Physical therapy evaluation	/ /	_____
☐ Psychiatric evaluation	/ /	_____
☐ Psychological evaluation	/ /	_____
☐ Neuropsychological evaluation	/ /	_____
☐ School testing	/ /	_____
☐ Speech / Language testing	/ /	_____
☐ Vision testing	/ /	_____
☐ Other: _____	/ /	_____

Services

Please provide copies of your most recent Individual Education Plan (IEP), Regional Center assessment or Individual Family Service Plan (IFSP), and any other relevant reports. In addition, please provide copies of any records, progress notes, or reports from any of the services checked below.

Intervention	Age range / Grade level of treatment	Minutes or # of sessions per week	Individual or Group	Name/Agency /Setting of Provider*	Credentials of Provider
Speech Ther. (Articulation)					
Language Therapy					
Occupational Therapy					
Physical Therapy					
Adaptive P.E.					
Educational Therapy					
Tutoring					
Educational Service (School Distr.)					
Educational Service (Private)					
Social Skills Training					
Psychotherapy					
Assistive Technology					
Classroom Accommodations					
Other:					

* Please provide the name of treatment provider. If clinic based, and more than one person provided treatment, please provide the name of the "lead" person.

6. DEVELOPMENTAL HISTORY

If adopted, please answer the following questions to the best of your knowledge.

If child was adopted, please indicate at what age: _____

During pregnancy, was the mother on any prescription medication? ☐ Yes ☐ No

If yes, what kind, for what problem, during what month, and for how long? _____

_____

_____

During pregnancy, did the mother smoke? ☐ Yes ☐ No

If yes, how many cigarettes each day? _____

During pregnancy, did the mother drink alcoholic beverages? ☐ Yes ☐ No

If yes, what did you drink? _____

Approximately how much alcohol was consumed each day / week? _____

During pregnancy, did the mother use drugs? ☐ Yes ☐ No

If yes, what kind? _____

Were there any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections(s), toxemia, etc)? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

_____

Duration of pregnancy (weeks): _____ Duration of labor (hours): _____

Were there any indications of fetal distress during labor or during birth? _____

_____

Were forceps used during delivery? _____

Was a Cesarean section performed? _____

Was delivery induced? _____

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

_____

_____

Was delivery breach? ☐ Yes ☐ No

Was delivery spontaneous normal vaginal delivery (SNVD)? ☐ Yes ☐ No

APGARs _____ Additional APGARs _____

Birth Weight: _____

Was your child premature? ☐ Yes ☐ No

If so, by how many months? _____

Were there any birth defects or complications? ☐ Yes ☐ No

If yes, please describe: _____

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

What was your first impression of your baby? _____

_____

Was your child breastfed? ☐ Yes ☐ No

If yes, for how long? _____

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 your child quiet? ☐ Yes ☐ No

As an infant, was your child alert? ☐ Yes ☐ No

As an infant, did your child like to be held? ☐ Yes ☐ No

As an infant, did your child maintain eye gaze? ☐ Yes ☐ No

As an infant, did your child attend to noises in the environment? ☐ Yes ☐ No

As an infant, did your child visually track objects? ☐ Yes ☐ No

As an infant, did your child appear "under-responsive" (tired, slow to react, etc)? ☐ Yes ☐ No

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

If so, describe:

Did not enjoy cuddling _____

Did not make eye contact _____

Did not anticipate / "mold" to being picked up _____

Arched back _____

Recoiled from touch _____

Was not calmed by being held or stroked _____

Colic (Describe, and for how long?) _____

Excessive restlessness _____

Prolonged diminished sleep _____

Head banging _____

Constantly into everything _____

Excessive number of accidents compared to other children _____

Cried a lot _____

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

☐ Yes ☐ No If yes, please describe: _____

_____

The following is a list of infant and preschool behaviors. *Please indicate the age at which your child first demonstrated each behavior. 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 behavior occurred, please write a question mark.*

Behavior	**Age**	**Behavior**	**Age**
Showed response to mother	_____	Spoke first word	_____
Smiled	_____	Spoke single words (other than "mama" or "dada")	_____
Rolled over	_____	Vocabulary burst	_____
Sat Alone	_____	Said phrases	_____
Crawled	_____	Said sentences	_____
Walked without assistance	_____	Dressed self (donning shirts/pants)	_____
Babbled	_____		

Buttoned clothing	_____	Rode tricycle	_____
Managed all fasteners	_____	Rode bicycle (without training wheels)	_____
Donned socks and shoes	_____	Named colors	_____
Tied shoelaces	_____	Named shapes	_____
Began to use utensils	_____	Named coins	_____
Mastered utensils	_____	Said alphabet in order	_____
Bladder trained, day	_____	Identified all letters accurately	_____
Bladder trained, night	_____	Began to read	_____
Stayed dry at night	_____		
Bowel trained	_____		

Rate your child on the following skills:

Walking	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Running	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Throwing	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Catching	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Overall athletic abilities	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Shoelace tying	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Cutting	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Manipulating small objects	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it
Writing (graphomotor)	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Can't do it

7. MEDICAL HISTORY

Date of last physical examination: _____

Date of last vision examination: _____

Date of last hearing examination: _____

Place a check next to any illness or condition that your child has had. When you check an item, also note approximate date (or age) of the illness.

Illness / Condition	Date(s) / Age(s)	Illness / Condition	Date(s) / Age(s)
☐ Measles	_____	☐ Dizziness	_____
☐ German measles	_____	☐ Frequent or severe headaches	_____
☐ Mumps	_____	☐ Difficulty concentrating	_____
☐ Chicken pox	_____	☐ Memory problems	_____
☐ Whooping cough	_____	☐ Extreme tiredness or weakness	_____
☐ Diphtheria	_____	☐ Rheumatic fever	_____
☐ Scarlet Fever	_____	☐ Epilepsy	_____
☐ Meningitis	_____	☐ Tuberculosis	_____
☐ Pneumonia	_____	☐ Bone or joint disease	_____
☐ Encephalitis	_____	☐ Gonorrhea or syphilis	_____
☐ High Fever	_____	☐ Anemia	_____
☐ Injuries to Head	_____	☐ Jaundice / Hepatitis	_____
☐ Broken bones	_____	☐ Diabetes	_____
☐ Hospitalizations	_____		
☐ Operations	_____		

☐ Cancer _____
☐ High blood pressure _____
☐ Heart disease _____
☐ Ear problems (disease, infection, injury, or impaired hearing) _____
☐ Otitis media _____
☐ Visual problems _____
What type: _____
☐ Fainting spells _____
☐ Loss of consciousness _____
Due to what: _____
☐ Paralysis _____

☐ Lead poisoning _____
☐ Exposure to toxin _____
☐ Stomach pumped _____
☐ Asthma _____
☐ Bleeding problems _____
☐ Eczema or hives _____
☐ Suicide attempt _____
☐ Suspicion of alcohol use _____
☐ Suspicion of drug use _____
☐ History of physical abuse _____
☐ History of sexual abuse _____

Medical Specialists: *(please include dates of evaluations / diagnoses given)*

Developmental Pediatrician _____

Neurology _____

Suspected seizures ☐ Yes ☐ No If yes, describe: _____

Seizures diagnosed ☐ Yes ☐ No If yes, type: _____

Genetics _____

Psychiatry _____

Gastroenterology _____

Stomach/intestinal problems ☐ Yes ☐ No If yes, type: _____

Endocrine _____

Allergy problems ☐ Yes ☐ No If yes, type: _____

Other: _____

Check the tests or evaluations that have been done in relation to the problem.

	Date (approx. O.K.)	Results (Your impressions are fine):
☐ Blood Work	/ /	_____
☐ CT Scan	/ /	_____
☐ EEG	/ /	_____
☐ Genetic Testing	/ /	_____
☐ Hearing Testing	/ /	_____
☐ MRI or PET	/ /	_____
☐ Neurologist's Exam	/ /	_____
☐ Other:	/ /	_____

Medication History

Current Medications *(please list name of medications, dosage, and frequency):*

1)_____ 4) _____

2)_____ 5) _____

3)_____ 6) _____

Prescribed by: _____ Last visit: _____

Pediatrician: _____ Last visit: _____

Neurologist: _____ Last visit: _____

Psychiatrist: _____ Last visit: _____

Other: _____

Current concerns: _____

_____

_____

Past Medications (*please list name of medications, when taken, and why stopped*): _____

_____

_____

_____

_____

8. 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. When you check an item, please note the member's relationship to the child.

Condition	**Relationship to Child**
☐ Problems with aggressiveness, defiance, and oppositional behavior as a child (underline those that apply)	_____
☐ Problems with attention, activity, and impulse control as a child (underline those that apply)	_____
☐ Behavior problems (please explain):	_____
☐ Learning disabilities	_____
☐ Trouble in school with academics (e.g. slow to learn, didn't like school, underachiever, etc.)	_____
☐ Mental retardation	_____
☐ Psychosis or Schizophrenia	_____
☐ Depression	_____
☐ Anxiety disorder that impaired adjustment	_____
☐ Emotional problems (please explain): _____	_____
☐ Tics or Tourette's	_____
☐ Alcohol abuse	_____
☐ Drug abuse	_____
☐ Suicide attempt	_____
☐ Antisocial behavior (assaults, thefts, legal problems, etc.)	_____
☐ Physical abuse	_____
☐ Sexual abuse	_____
☐ Mental / Verbal abuse	_____
☐ Cancer	_____
☐ Diabetes	_____
☐ Heart trouble	_____
☐ Neurological condition (s)	_____

Have there been any stressors, that I should know of (illness, deaths, operations, accidents, separations, divorce of parents, parent changed job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses, other stressor information)? _____

_____

_____

_____

9. BEHAVIOR AND DISCIPLINE

How often does your child behave inappropriately? _____

Does your child's behavior disrupt family activities / events / outings? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

What disciplinary techniques do you usually use when your child behaves inappropriately? (*Place a check next to each technique that you usually use. There is also space for writing in any other disciplinary techniques that you 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 techniques
- ☐ Tell child to sit on chair
- ☐ Send child to his/her room
- ☐ Spank child
- ☐ Other technique (describe) _____

_____

Does your child respond differently based upon who is giving the discipline? (Describe.) _____

_____

Which disciplinary techniques are usually most effective? _____

_____

What disciplinary techniques are usually ineffective? _____

_____

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

_____

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

_____

Who typically disciplines your child? _____

To what extent are you and other caretakers consistent with respect to disciplinary strategies? _____

_____

In general, what have you found to be the most satisfactory ways of helping your child? _____

_____

Has your child ever been in trouble with drugs? ☐ Yes ☐ No

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

If yes, please describe briefly: _____

_____

_____

10. OTHER INFORMATION

Is there any other information that you think may help me in assessing your child? _____

Is there anything else you would like me to know? _____