Family Guiding

SOCIAL AND DEVELOPMENTAL HISTORY

The following is a parent questionnaire designed to provide background information, which will be helpful in understanding your child's social, emotional and behavioral needs. Please complete all questions to the best of your knowledge.

Child's Name: _____ **Date of Birth**: _____

Name of person completing form: _____

Relationship to the Child: _____

1. REASON FOR SEEKING THERAPY:

Please tell us what brings you to Family Guiding:

_____

_____

_____

_____

_____

_____

Does your child have any issues with the following (please check all that apply):

- ☐ Thumb sucking
- ☐ Bed Wetting
- ☐ Temper Tantrums
- ☐ Aggression (e.g. hitting/kicking)
- ☐ Anxiety/Nervous Habits
- ☐ Attention (e.g. difficulty focusing)
- ☐ Hyperactivity
- ☐ Academic Problems

If you checked any of the above please describe below:

_____

_____

_____

Please describe how often and for how long your child has been experiencing difficulties. When did you first notice these issues?

_____

_____

_____

2. PRENATAL AND BIRTH HISTORY

Length of Pregnancy: ☐ Preterm ☐ Term ☐ Post-term

Child's approximate birth weight: _____

Please describe the child's birth process (i.e. normal delivery, induced, Caesarean etc):

_____

_____

_____

Please describe any prenatal or birth complications, if any?

_____

_____

_____

3. DEVELOPMENTAL HISTORY

A) Please record the approximate age at which your child reached the following developmental milestones.

B) If you cannot recall exactly, check one of the boxes:

	Age:	Normal	Early	Late	N/A
Rolled over:	_____	☐	☐	☐	☐
Sat without support:	_____	☐	☐	☐	☐
Crawled	_____	☐	☐	☐	☐
Stood without support:	_____	☐	☐	☐	☐
Walked:	_____	☐	☐	☐	☐
Running:	_____	☐	☐	☐	☐
Spoke first words:	_____	☐	☐	☐	☐
Said two word phrases:	_____	☐	☐	☐	☐
Toilet trained:	_____	☐	☐	☐	☐
Dressed self:	_____	☐	☐	☐	☐

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

☐ Did not enjoy cuddling
☐ Was not calmed by being held/stroked
☐ Constantly getting into everything
☐ Frequent head-banging
☐ Excessive restlessness
☐ Diminished sleep
☐ Difficult to comfort
☐ Difficulty nursing
☐ Colic/ excessive irritability

If you checked any of the above, please describe more details below:

_____

_____

_____

4. MEDICAL AND PSYCHIATRIC HISTORY

Please describe any significant medical history (e.g. illness, surgeries, head injury, seizures, etc).

_____

_____

_____

Please give the name and address of your child's Pediatrician or Primary Care Provider:

_____

_____

_____

Is your child taking any medications? ☐ Yes ☐ No

If yes, please list medications and dosages below:

_____

_____

Has your child received psychological or psychiatric services before? ☐ Yes ☐ No

If yes, please give the name and address of the provider:

_____

_____

Please provide a brief description of the type of treatment received:

_____

_____

_____

_____

What is the reason for stopping services?

_____

_____

Is there any significant family history of mental or medical illness? ☐ Yes ☐ No

If yes, please describe:

_____

_____

5. SOCIAL-EMOTIONAL DEVELOPMENT

Does your child play/interact primarily with peers his/her own age? ☐ Yes ☐ No

Does your child seek out or initiate play/interaction with others? ☐ Yes ☐ No

Does your child show cooperative play, such sharing, taking turns and following the rules of a game? ☐ Yes ☐ No

When your child gets angry/upset please describe how he/she handles it and what helps to calm him/her?

_____

_____

_____

_____

_____

Please use the space below to describe your child, including positive traits, strengths, and any other concerns his or her development and behavior that has not been asked:

_____

_____

_____

_____

_____