DRM Consulting Services Inc.
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CHILD AND FAMILY SURVEY

This information is considered confidential and will not be released without written permission of parents and/or guardian. Please complete the form and provide details where possible.
Date form completed: _____ Referral Source:_____

PART I Identifying Information

Child's Name: _____ D.O.B.: _____
Gender: _____ Telephone number: _____
Address:_____
Mother's Name: _____Father's Name_____
Parents' marital status: Circle one:
Married, Divorced, Separated, Never Married, Living Together
Medicaid Number: _____

PART II Reason for Referral

What is the main concern and what are some of the behaviors you observe that make you suspect there is a problem?_____
_____
_____
Does the present problem occur at home? _____ school? _____ other?_____
Are there other concerns?_____

Social and Behavioral Questions

Place a check to any behavior or problem that your child currently exhibits:

_____Has difficulty with speech (articulation or producing sounds)
_____Has difficulty with hearing
_____Has difficulty with language
_____Has difficulty with vision
_____Has poor bowel control
_____Has difficulty with coordination
_____Wets bed
_____Is much too active
_____Is distractible/short attention span
_____Is fearful
_____Has frequent tantrums
_____oppositional/defiant
_____Has frequent nightmares
_____Has trouble sleeping
_____Has poor appetite
_____Has memory problems
_____Has attachment problems
_____Is aggressive
_____Is slow to learn
_____Is impulsive
_____Does not get along with peers

Please use this space to describe any problems in more detail:_____
_____
_____
Does he/she have a problem controlling his temper or with controlling anger? (describe)
_____
_____

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Does he/she ever get sad or withdrawn? (describe)_____
_____
How does this child react to stress and frustration? (describe)_____
_____
Does the child seem more clumsy than other children?_____
Does the child have a hard time sitting still and paying attention to things? (describe)_____

Does the child have any problems playing with children out side the home? (describe) __
_____
How does the child get along with other family members? _____
Does his/her behavior cause difficulty within the family? _____
When was the problem first observed and by whom? _____
What was done at that time? _____
Has child been evaluated for the current problem before? Circle: Yes No
If yes, when and by whom? _____
Has the child or other family member seen a psychiatrist or psychologist previously?
Yes: _____ No: _____ If yes, was it in reference to this or another problem?
Same: _____ Different: _____ If different, please explain.
_____

PART II: Family Information
Please list those persons who are important in your child's life.

Household Occupants	Age	Relationship	Occupation	Lives with child (yes/no)

Has your family ever had genetic studies done? Y or N
Where and Why /Results:_____
Are there any other family members with similar problems to those you mentioned?_____
_____
Has anyone in the family of either parent had any of the following problems?

	Yes	No	Relationship to Child
Learning Problems in School	____	____	_____
Mental Retardation	____	____	_____
Sickle Cell	____	____	_____
Diabetes	____	____	_____
Blindness	____	____	_____
Seizures	____	____	_____
Alcoholism	____	____	_____
Depression	____	____	_____
Mental Health Disorder	____	____	_____

Birth Defect	____	____	_____
TB	____	____	_____
Cancer	____	____	_____
Deafness	____	____	_____
Cerebral Palsy	____	____	_____
OTHER:	____	____	_____

Is the child adopted? Yes: ___ No: ___ How long has the child lived in the current home?_____
When was the child initially placed outside the birth home? _____
Why?_____
How many placements has the child had? _____
What were you told about the child's history?____
_____

PART III Prenatal, Birth and Developmental History
During pregnancy, did the child's mother use any of the following:
____Tobacco ____Alcohol ____Medications ____Drugs
Weight at Birth: _____ Length at Birth: _____
Length of Labor: _____ Type of Delivery: Vaginal_____; C-Section____
Any problems during the birth?: Y or N
Full Term: Y or N If not, how many weeks' gestation? _____
Did the child breathe on his/her own at birth? Y or N Was Oxygen required? Y or N
Explain: _____
This is a list of developmental milestones. Please give the approximate age when your child did reach the following. If the child cannot accomplish the item please indicate that by writing "no" in the space.

Finger fed	_____	**Cooed**	_____
Undressed completely	_____	**Understood "no"**	_____
Tie shoes	_____	**Laughed aloud**	_____
Toilet trained	_____	**Gestures (waving bye, pat-a-cake)**	_____
Rolled over	_____	**Followed one command (without you pointing)**	_____
Sat unassisted	_____	**Said First Words**	_____
Crawled	_____	**Put Two Words Together**	_____
Walked	_____		
Points to 5 body parts (where are your eyes, etc.)	_____		

PART IV Medical History

Have there been any health problems? _____ If yes, please explain_____
_____
_____
Has he/she ever been hospitalized?_____
_____

Has he/she ever had surgery?_____
_____
When was the last eye exam? _____Results: _____

When was the last hearing exam? _____Results: _____
Does he/she have allergies? Y or N (please list)_____
_____
Are his/her immunizations up to date? Y or N

Medications: Please list any medications your child currently takes regularly?

Name	Frequency	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician name: _____Telephone number:_____
Physician name: _____Telephone number: _____

PART V Educational History

Name of school:_____Grade:_____ Special Ed Services: Circle one: YES NO
Teacher and/or Counselor:_____Has your child had any educational testing? YES NO
What grades does your child typically earn?_____
Does your child receive: speech therapy___occupational therapy____physical therapy___
If so, what type, where and when? (date of last assessment)_____
_____
Has your child been held back in a grade? YES NO
Number of schools your child has attended_____
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
_____Does not get along with classmates
_____Has behavior problems
_____Does not like school
_____Has difficulty with writing

What are your child's strengths?_____
What are your child's favorite activities?_____
What is your child's temperament like?_____
Is there any other information that you think may help us in working with your child____
_____
_____

For Professional Use Only

_____
_____
_____