



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:

- | | |
|---|--|
| <input type="checkbox"/> Has difficulty with speech
(articulation or producing sounds) | <input type="checkbox"/> Has frequent tantrums |
| <input type="checkbox"/> Has difficulty with hearing | <input type="checkbox"/> oppositional/defiant |
| <input type="checkbox"/> Has difficulty with language | <input type="checkbox"/> Has frequent nightmares |
| <input type="checkbox"/> Has difficulty with vision | <input type="checkbox"/> Has trouble sleeping |
| <input type="checkbox"/> Has poor bowel control | <input type="checkbox"/> Has poor appetite |
| <input type="checkbox"/> Has difficulty with coordination | <input type="checkbox"/> Has memory problems |
| <input type="checkbox"/> Wets bed | <input type="checkbox"/> Has attachment problems |
| <input type="checkbox"/> Is much too active | <input type="checkbox"/> Is aggressive |
| <input type="checkbox"/> Is distractible/short attention span | <input type="checkbox"/> Is slow to learn |
| <input type="checkbox"/> Is fearful | <input type="checkbox"/> Is impulsive |
| | <input type="checkbox"/> 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)

Does he/she ever get sad or withdrawn?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 behavior problems |
| ___ Has difficulty with arithmetic | ___ Does not like school |
| ___ Has difficulty with spelling | ___ Has difficulty with writing |
| ___ Does not get along with classmates | |

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
