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Licensed Psychologist
248-962-5064

CHILD BACKGROUND QUESTIONNAIRE (FAMILY)

Child's Full Name:

Today's Date:

Age:	Date of Birth: / /	Gender: ❑ Male ❑ Female ❑ Non-Binary/ Other

Address: City: Zip code:

School: Grade:

Pediatrician/Physician: Phone # of Pediatrician/Physician: ( ) — —

Person filling out this form: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Other (please explain)*

* Other:

If necessary, I give Dr. Radtke-Rounds permission to call me at the following numbers:

Home Phone:	( ) —	OK to leave a message?	❑ Yes ❑ No
Father's Work Phone:	( ) —	OK to leave a message?	❑ Yes ❑ No
Mother's Work Phone:	( ) —	OK to leave a message?	❑ Yes ❑ No
Father's Cell Phone	( ) —	OK to leave a message?	❑ Yes ❑ No
Mother's Cell Phone	( ) —	OK to leave a message?	❑ Yes ❑ No
Other:	( ) —	OK to leave a message?	❑ Yes ❑ No

Name	Age	Occupation
Parent 1 Name:		
Parent 2 Name:		
Stepparent's Name:		

Marital status of Parents:	If Parents are separated/divorced, how old was child at time of separation?	Age

List all people living in household:

Name	Relationship	Name	Relationship

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

Name of Brother or Sister living outside home	Age	Name of Brother or Sister living outside home	Age

Primary language spoken in the home: _____

Other languages spoken in the home: _____

PRESENTING PROBLEM

Briefly describe your child's current difficulties:

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

Has the child received evaluation or treatment for the current problem or similar problems? ❑ Yes ❑ No

If yes... _____ _____

When? With whom?

Is the child on any medication at this time? ❑ Yes ❑ No	If **yes**, please note kind of medication:

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.
Check all that apply

- ❍ 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 other children
- ❍ Is aggressive
- ❍ Is shy or timid
- ❍ Is more interested in things (objects) than in people
- ❍ Has poor bowel control (soils self)
- ❍ Engages in behavior that could be dangerous to self
- ❍ Is much too active
- ❍ Has special fears, habits, or mannerism
- ❍ Show daredevil behavior
- ❍ Gives up easily
- ❍ Wets bed
- ❍ Bites nails
- ❍ Engages in repetitive behavior
- ❍ Has difficulty making decisions
- ❍ Has sensitivities to clothing (e.g., tags, manner in which wears socks)
- ❍ Has lengthy rituals related to going to the bathroom, washing hands
- ❍ Has many anxieties/specific fears
- ❍ Has frequent tantrums
- ❍ Has frequent nightmares
- ❍ Has trouble sleeping
- ❍ Has blank staring spells
- ❍ Rocks back and forth
- ❍ Bangs head
- ❍ Holds breath
- ❍ Eats poorly
- ❍ Is stubborn
- ❍ Is impulsive
- ❍ Sucks thumb
- ❍ Is slow to learn
- ❍ Is a picky eater
- ❍ Has difficulty adjusting to changes
- ❍ Other problems/concerns:

_____

_____

_____

EDUCATIONAL HISTORY

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

- ❍ Has difficulty with reading
- ❍ Has difficulty with arithmetic
- ❍ Has difficulty with other subjects (please list)
- ❍ Has difficulty with spelling
- ❍ Has difficulty with writing
- ❍ Does not like school

_____

_____

Is your child in a special education class? ❑ Yes ❑ No

If **yes**, what type of class? _____

Has your child been held back in a grade? ❑ Yes ❑ No

If **yes**, what grade and why? _____

Has your child ever received special tutoring or therapy in school? ❑ Yes ❑ No

If **yes,** Please describe the special tutoring or therapy in school:

_____