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CHILD BACKGROUND QUESTIONNAIRE

Child's Name:	Date of Birth:	Age:	Gender:
School:	Grade: *If summer, grade just completed.*		

Home Address:

Person completing this form:	Date form completed:
Pediatrician/Physician:	Who referred you to our office?

Family Information:

Parent/Guardian (Circle relationship to child)	Full Name	Occupation	Highest Level of Education
Mother Father Guardian			
Mother Father Guardian			
Mother Father Guardian			
Mother Father Guardian			

Marital status of parents: _____

If parents are separated/divorced, how old was child at time of separation? _____

If necessary, I give McCaskill Family Services permission to call me at the following phone numbers:

Parent/Guardian	Work Number	Ok to leave message?	Cell Number	Ok to leave message?	Home Number	Ok to leave message?
		Y N		Y N		Y N
		Y N		Y N		Y N
		Y N		Y N		Y N
		Y N		Y N		Y N

List all people living in child's household:

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: _____

Name of person responsible for bill: _____ SS# _____

Are you or your child involved in any legal issues at this time (i.e., probation, divorce, custody issues, etc.): Yes No

If yes, please explain: _____

Presenting Problem

Place a check next to any areas that your child is currently experiencing difficulties with or for which you have concerns:

<input type="checkbox"/>	Speech & language	<input type="checkbox"/>	Specific fears or phobias
<input type="checkbox"/>	Coordination	<input type="checkbox"/>	Tics or repetitive behaviors
<input type="checkbox"/>	Toileting accidents	<input type="checkbox"/>	Rigid/repetitive rituals or routines
<input type="checkbox"/>	Stubborn/strong-willed behavior	<input type="checkbox"/>	Prefers to be alone
<input type="checkbox"/>	Aggression	<input type="checkbox"/>	Bites nails or has other nervous habits
<input type="checkbox"/>	Impulsive behavior	<input type="checkbox"/>	Easily stressed/anxious
<input type="checkbox"/>	Bangs head/hurts self	<input type="checkbox"/>	Does not get along with siblings
<input type="checkbox"/>	Is too active (e.g., trouble sitting still, high energy)	<input type="checkbox"/>	Does not get along well with friends/peers
<input type="checkbox"/>	Excessive video game playing/technology use	<input type="checkbox"/>	Making and/or keeping friends
<input type="checkbox"/>	Following directions	<input type="checkbox"/>	Is shy or timid
<input type="checkbox"/>	Attention/focus	<input type="checkbox"/>	Is more interested in things than in people
<input type="checkbox"/>	Motivation levels	<input type="checkbox"/>	Recognition of social cues
<input type="checkbox"/>	Behavior that is dangerous to self or others	<input type="checkbox"/>	Blank staring spells

Tantrums/Meltdowns	Frequency:	Intensity:
Homework/study habits		
Grades		

Eating habits (e.g., excessive/restricted eating, picky eater, nutritional imbalance)
Frequent nightmares
Sleep

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

If yes, please describe briefly:

Describe your child's current difficulties that are of most concern (feel free to use back of this form or attach additional pages to further elaborate if needed):

How long has this problem been of concern to you?	
When was the problem first noticed?	
What seems to help the problem?	
What seems to make the problem worse?	

Has your child ever participated in a psychoeducational, neuropsychological or other evaluation for learning, emotional, or behavioral concerns? Please list evaluation history below:

Evaluator/Clinic Name	Date(s) of Evaluation	Findings and/or Diagnoses Received

Has your child ever participated in therapy for treatment of emotional, behavioral or other mental health concerns? Please list history below:

Therapist/Clinic Name	Dates of Treatment	Findings or Diagnoses Received

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you have used within the past year. There also is space for writing in any other disciplinary techniques that you use.

Ignore problem behavior	Redirect child's interest
Scold child	Reason with child
Tell child to sit on chair	Don't use any technique
Send child to their room	Other
Spank child	Other:
Threaten child with consequence/punishment	Other
Take away some activity or food	Other:

Which disciplinary techniques are usually effective? _____

With what type of problem? _____

Which disciplinary techniques are usually ineffective? _____

With what type of problem? _____

What have you found to be the most satisfactory ways of helping your child? _____

What are your child's assets or strengths? _____

What are your child's favorite activities? _____

What activities would your child like to engage in more often than they do at present? _____

What activities does your child like least? _____

Developmental History

Was your child adopted? If yes, what age were they at the time of adoption? _____

Was your child conceived via egg and/or sperm donor? If yes, please explain. _____

Prenatal History

During pregnancy, was mother on medication?	Yes or No	If yes, what kind?
During pregnancy, did mother smoke?	Yes or No	If yes, how many cigarettes each day?
During pregnancy, did mother drink alcoholic beverages?	Yes or No	If yes, what kind and amount?
During pregnancy, did mother use drugs?	Yes or No	If yes, what kind and frequency?
Did mother experience any medical complications during pregnancy?	Yes or No	If yes, explain.

Labor and delivery

Was the child premature?	Yes or no	If so, by how many months?
Were forceps used during delivery?	Yes or No	If so, were there any related complications?
Was a Cesarean section performed?	Yes or No	If yes, for what reason?
What was the child's birth weight?		
Were there any birth defects or complications?	If yes, explain complications and treatment.	

Infancy

		Comments/Notes
Any concerns with infant temperament (e.g., excessively quiet, excessive crying, unresponsive to parental voice/interactions, concerns with being held)? If yes, please comment.	Yes or no	
Were there any feeding problems? If yes, please comment.	Yes or No	
Were there any sleeping problems? If yes, please comment.	Yes or No	
Please describe any special problems in growth and development of the child during the first few years:		

Developmental Milestones:

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		Babbled	
Rolled over		Said first word	
Sat alone		Put several words together	
Crawled		Dressed self	
Walked alone		Became toilet trained	
Rode tricycle		Stayed dry at night	
Rode bicycle		Fed self	

Educational History:

Learning Area	Problem area? Yes or No	When was this problem first noticed?
Reading		
Arithmetic		
Spelling		
Handwriting		
Written expression (e.g., grammar, punctuation, organization, clarity, fluency)		
Attitude towards school		
Organization/study habits		
Other:		
Other:		
Other:		

Has your child received formal or informal services and/or academic accommodations/supports to address learning weaknesses? Yes or No

*****If yes, please complete the Educational Intervention History Form attached at the end of the Child Background Questionnaire*****

Medical History:

Medical providers:

Current pediatrician/physician:	How long has your child been seen by this provider?
Phone #:	Fax #:

Address:

Past pediatrician/physician:	When your child seen by this provider?
Phone #:	Fax #:

Address:

Other (e.g., psychiatrist, specialist)	When was your child seen by this provider?
Phone #:	Fax #:

Address:

Allergies:

Allergy	Reaction

Current Medications:

Name of Medication	Prescribed by	Date your child began medication	Current dosage & date dosage was started	Previous dosage(s) & date dosage(s) prescribed

Medication History:

Name of Medication	Prescribed by:	Dosage	Date your child began medication.	Date your child stopped taking this medication

History of illness/medical conditions:

Place a check next to any illness or condition that your child has had. When you check an item, also note the date(s) or age(s) when illness or condition was diagnosed/experienced.

Check	Illness or Condition	Date(s)/Age(s)
	Measles	
	German measles	
	Mumps	
	Chicken Pox	
	Whooping cough	
	Extreme tiredness	
	Weakness	
	Growth delays	
	Diphtheria	
	Scarlet fever	
	Rheumatic fever	
	Meningitis	
	Epilepsy	
	Tuberculosis	
	Bone or joint disease	
	Gonorrhea or syphilis	
	Anemia	
	Jaundice/hepatitis	
	Diabetes	
	Cancer	
	High blood pressure	
	Heart disease	
	Other:	

Check	Illness or Condition	Date(s)/Age(s)
	Asthma	
	Bleeding Problems	
	Visual Problems	
	Hearing Problems	
	Frequent/Severe Headaches	
	Dizziness/Fainting	
	Eczema or Hives	
	Suicide attempt	
	Hospitalization related to suicidal thoughts/behaviors	
	Memory problems	
	Paralysis	
	Loss of consciousness	
	Concussion	
	Encephalitis	
	High fever	
	Convulsions/seizures	
	Hay fever	
	Head injuries	
	Broken bones	
	Hospitalizations	
	Operations	
	Ear problems	
	Other:	

Family Medical History:

Place a check next to any illness or condition that any member of the child's family has had (or suspected). When you check an item, please note the member's relationship to the child.

Check	Condition	Relationship to child	Check	Condition	Relationship to child
	Alcoholism			Depression	
	Cancer			Learning disability Specify type:	
	Diabetes			ADHD	
	Heart trouble			Cognitive impairment	
	Genetic Disorders			Developmental delay	
	Bipolar Disorder			Autism	
	Anxiety Disorder			Other:	

I think it would be helpful for my clinician/therapist to contact the following professionals who also participate or have participated in my child's care (e.g., physicians, therapists, tutors, etc.).

Professional's Name & Profession	Phone Number	Fax Number	E-mail Address	Mailing Address

****Please see clinician/therapist to sign an authorization form so that he/she may contact the professionals cited above. ****

Please use this space (or attach additional pages) for any other information that would be helpful for us to know when working with your child. Thank you.

My signature below indicates that the information contained in this document is true to the best of my knowledge.

Signature: _____

Date: _____

Educational Intervention History Form:

This form is to help document both formal and informal interventions that have helped your child to succeed throughout his/her academic career. This includes interventions such as: at-home tutoring, IEP/504plans, extra support from teachers, therapy, structured homework time at home etc. For your convenience, you will find an attached list of commonly implemented support services that children tend to receive over the course of their academic career. Please be as specific as possible, (we know it's hard to remember!) documenting length and frequency of intervention, wherever possible.

Grade	Formal Intervention	Informal Intervention	Concerns/Comments
<i>Ex:</i> 5 th	<i>-Speech and language therapy through school. Once per week for the whole year.</i> <i>-Cognitive behavioral therapy at McCaskill Family services for anxiety. 6 months.</i>	<i>-5th grade teacher would always allow Marie to finish her tests during recess, if she was unable to complete them during class time.</i> <i>-Started making visual flashcards with parents for big exams.</i>	<i>-Had a hard time staying on task and finishing homework</i> <i>-Lots of arguing at home between mom and Marie, mostly about school.</i>
K			
1 st			
2 nd			
3 rd			
4 th			
5 th			
6 th			

7 th			
8 th			
9 th			
10 th			
11 th			
12 th			

Examples of Frequent Formal and Informal Interventions:

504/IEP/Student Accommodation Plan	Services/meetings with school counselor or school social worker
At-home private tutoring	Frequent parent monitoring to help child prioritize/organize (e.g., task list, calendars).
Tutoring through an agency (e.g., Sylvan, Brainspring)	Parent frequently helps child to stay on task during study time
Parent implemented organizational system	Teacher moving student to front of class to help with focus/behavior
Enrollment in study skills class	Individualized “color chart” or behavioral reward system in school
Individual, family or parent psychotherapy	Teacher providing extra time to take tests or complete assignments
Use of assistive technology	Parent/tutor help implement specific, structured study strategies at home
Use of audiobooks	Speech & Language Therapy