Website: www.mccaskillfamilyservices.com
E-mail: office@mccaskillfamilyservices.com
Fax: 734-416-0158

Plymouth Location:
409 Plymouth Rd., Suite 250, Plymouth, MI 48170
734-416-9098
Brighton Location:
2040 Grand River Annex, Suite 300, Brighton, MI 48114
810-224-1676

CHILD BACKGROUND QUESTIONNAIRE

Child's Name:	**Date of Birth:**	**Age:**	**Gender:**
School:	**Grade:** ***If summer, grade just completed.***		
Home Address:	**City**	**State:**	**Zip Code:**
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, or has your child ever been involved with the law? (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:

	Speech & language		Specific fears or phobias
	Coordination		Tics or repetitive behaviors
	Toileting accidents		Rigid/repetitive rituals or routines
	Stubborn/strong-willed behavior		Prefers to be alone
	Aggression		Bites nails or has other nervous habits
	Impulsive behavior		Easily stressed/anxious
	Bangs head/hurts self		Does not get along with siblings
	Is too active (e.g., trouble sitting still, high energy)		Does not get along well with friends/peers
	Excessive video game playing/technology use		Making and/or keeping friends
	Following directions		Is shy or timid
	Attention/focus		Is more interested in things than in people
	Motivation levels		Recognition of social cues
	Behavior that is dangerous to self or others		Blank staring spells
	Tantrums/Meltdowns Frequency: Intensity:		Eating habits (e.g., excessive/restricted eating, picky eater, nutritional imbalance)
	Homework/study habits		Frequent nightmares
	Grades		Sleep

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
	Alcoholism	
	Cancer	
	Diabetes	
	Heart trouble	
	Genetic Disorders	
	Bipolar Disorder	
	Anxiety Disorder	

Check	Condition	Relationship to child
	Depression	
	Learning disability Specify type:	
	ADHD	
	Cognitive impairment	
	Developmental delay	
	Autism	
	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
Ex: 5th	*-Speech and language therapy through school. Once per week for the whole year.* *-Cognitive behavioral therapy at McCaskill Family services for anxiety. 6 months.*	*-5th grade teacher would always allow Marie to finish her tests during recess, if she was unable to complete them during class time.* *-Started making visual flashcards with parents for big exams.*	*-Had a hard time staying on task and finishing homework* *-Lots of arguing at home between mom and Marie, mostly about school.*
K			
1st			
2nd			
3rd			
4th			
5th			
6th			

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

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