Anan & Associates

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CHILD BACKGROUND QUESTIONNAIRE

Child's Name : _____ **Today's date :** _____

Child's Date of Birth : _____ **Gender**: ☐ Male ☐ Female

Address: _____ **City:** _____ **Zip Code:** _____

Primary Physician & Address : _____

Child's School & District: _____ **Grade:** _____ **Teacher:** _____

Name of person filling out this form : _____

Relationship to child : ☐ Mother ☐ Father ☐ Other relationship (specify): _____

Who referred you to Anan & Associates? _____

I permit Anan & Associates to contact me via phone using the following phone number(s) :

**do not include if unacceptable to leave message*

Home _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Home _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Cell _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Cell _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Work _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Work _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Other _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

I permit Anan & Associates to contact me via email using the following email address(es) :

Email _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Email _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Email _____ ☐ Self ☐ Spouse ☐ other *(specify)*: _____

Name and contact information of person responsible for the bill:

_____

Mother's name: _____ **Occupation:** _____

Father's name: _____ **Occupation:** _____

Marital status of parents *:

☐ Married ☐ Separated ☐ Divorced ☐ Other (*please specify*) : _____

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

Please list all people currently living in the same household as the child:

Name	Relationship to Child	Age

If there are any brothers or sisters currently living *OUTSIDE* the home, please provide their names and ages below:

_____

If English is not the primary language spoken in the home, what language is used and how often?

_____

PRESENTING PROBLEM

Please briefly describe your child's current difficulties:

When was the problem first noticed or how long has it been a concern?

What seems to *help* the problem?

What seems to make the problem *worse*?

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

*If **yes**, when and with whom?

Is the child on any medication at this time*? ☐ Yes ☐ No

*If **yes**, please list the **name** and **daily dosage** of the medication(s) the child is currently taking below :

SOCIAL AND BEHAVIOR CHECKLIST

Please check next to any of the following behaviors or problems that your child currently exhibits :

- ☐ Has difficulty with speech or language
- ☐ Has difficulty with hearing
- ☐ Has difficulty with vision
- ☐ Has difficulty with coordination
- ☐ Is slow to learn
- ☐ Gives up easily
- ☐ Prefers to be alone
- ☐ Is shy or timid
- ☐ Is aggressive
- ☐ Shows daredevil behavior
- ☐ Is much too active
- ☐ Eats poorly
- ☐ Wets pants
- ☐ Has frequent tantrums
- ☐ Has frequent nightmares
- ☐ Rocks back and forth
- ☐ Bangs head
- ☐ Has blank spells
- ☐ Sucks thumb
- ☐ Holds breath
- ☐ Is more interested in objects than in people
- ☐ Is stubborn
- ☐ Is impulsive
- ☐ Is clumsy
- ☐ Has poor bowel control (soils self)
- ☐ Wets bed
- ☐ Does not get along well with brothers and sisters
- ☐ Has trouble sleeping (*please describe sleep troubles*): _____

_____

- ☐ Has unusual fears or anxieties (*please provide examples*): _____

_____

- ☐ Has special rituals, habits or mannerisms (*please provide examples*): _____

_____

- ☐ Engages in actions potentially dangerous to self or others (*please provide examples*):_____

_____

- ☐ Other problem(s) not listed above (*please provide brief description(s)*): _____

_____

_____

EDUCATIONAL HISTORY

Please check next to any educational problem that your child currently exhibits :

☐ Has difficulty with reading ☐ Has difficulty with spelling

☐ Has difficulty with writing ☐ Has difficulty with math

☐ Has difficulty with social aspects of school ☐ Does not like school

☐ Has difficulty with other subjects or activities at school (*please list additional problem(s) below*):

_____

_____

Does your child have an IEP*? ☐ Yes ☐ No

*If **yes**, please list your child's IEP certification, type of class, and support services:

_____

_____

Has your child ever been held back in a grade*? ☐ Yes ☐ No

*If **yes**, please tell us what grade your child was in and why he/she was held back below :

_____

_____

Has your child received tutoring outside of school*? ☐ Yes ☐ No

*If **yes**, please provide details about the tutoring below :

_____

_____

_____

DEVELOPMENTAL HISTORY

- PREGNANCY

During pregnancy, did the child's mother ever :

Take any type of medication? ☐ Yes ☐ No *If **yes**, what kind?* _____

Smoke Ciggarettes? ☐ Yes ☐ No *If **yes**, how many cigarettes/day?* _____

Drink alcoholic beverages? ☐ Yes ☐ No *If **yes**, how much per day?* _____

Use recreational drugs? ☐ Yes ☐ No *If **yes**, what kind & how often?* _____

- DELIVERY

Were forceps used during delivery? ☐ Yes ☐ No

Was a Cesarean section performed*? ☐ Yes ☐ No

If **yes, for what reason?* _____

_____

Were there any birth defects or complications*? ☐ Yes ☐ No

If **yes, please describe*: _____

_____

Was the child premature? ☐ Yes ☐ No *If **yes**, by how many weeks?* _____

What was the child's birth weight? ___ lbs ___ oz

- INFANCY, GROWTH & DEVELOPMENT

As an infant, did the child like to be held? ☐ Yes ☐ No

Were there any feeding problems*? ☐ Yes ☐ No

If **yes, please describe*: _____

_____

Were there any sleeping problems*? ☐ Yes ☐ No

If **yes, please describe*: _____

_____

Were there any problems in the child's growth & development during the first few years*? ☐ Yes ☐ No

If **yes, please describe*: _____

_____

Please provide the age or an estimated age at which your child first demonstrated each of the following developmental milestones:

MILESTONE	ESTIMATED AGE
Showed response to mother	_____
Rolled over	_____
Sat alone	_____
Crawled	_____
Walked alone	_____
Babbled	_____
Spoke first word	_____
Put several words together	_____
Dressed self	_____
Became toilet trained	_____
Stayed dry at night	_____
Fed self	_____
Rode tricycle	_____
Rode without training wheels	_____

CHILD'S MEDICAL HISTORY

Does your child have any food or medication allergies*? ☐ Yes ☐ No

*If **yes**, please list/describe below :

_____

_____

_____

_____

Has your child ever needed to see a pediatric physician specialist*? ☐ Yes ☐ No
(ex: ENT, Neurology, GI, Allergy, PM&R (physical medicine and rehabilitation), etc.)

*If **yes**, please list the ***type of specialty***, ***physician name(s)***, ***and reason for visit(s)*** below :

_____

_____

_____

_____

Has your child ever needed any pediatric therapies*? ☐ Yes ☐ No
(*ex: OT, PT, speech/language therapy, etc.*)?

*If **yes**, please provide details below:

_____

_____

_____

_____

Please check below next to any illness or condition that your child has had :
If possible, please also include the approximate date (or age) of the illness

	Date(s) or age(s)		Date(s) or Age(s)
☐ Broken bones		☐ Severe headaches	
☐ Head injury		☐ Dizziness/fainting	
☐ Other serious injury		☐ Extreme tiredness	
☐ Seizures		☐ Heart problems	
☐ Asthma		☐ Bone or joint disease	
☐ Hospitalizations		☐ Diabetes	
☐ Surgeries		☐ Cancer	
☐ Hearing/ear problems		☐ Bleeding problem	
☐ Vision/eye problems		☐ Suicide attempt	
☐ Other health problem(s)*			

**Please describe below, including date(s) or age(s) if possible* :

FAMILY MEDICAL HISTORY

Please check next to any illness or condition that any member of the child's family has had :
Please also include the family member's relationship to the child

	Relationship to child		**Relationship to child**
☐ Alcoholism	_____	☐ Drug abuse	_____
☐ ADD/ADHD	_____	☐ Learning disability	_____
☐ Schizophrenia	_____	☐ Mental Retardation	_____
☐ Bipolar Disorder	_____	☐ Autism Spectrum	_____
☐ Anxiety Disorder	_____	☐ Depression	_____

☐ Other mental health disorder(s) :

**Please describe below, including date(s) or age(s) if possible* :

_____

_____

_____

OTHER INFORMATION

What are some of your child's favorite activities?

1. _____
2. _____
3. _____
4. _____
5. _____

What are some activities would your child like to engage in more often than he/she does at present?

1. _____
2. _____
3. _____

What activities does your child like least?

1. _____
2. _____
3. _____

Please check next to any of the disciplinary techniques listed below that you usually use when your child behaves inappropriately :
If there are techniques you use that are not mentioned below, please write them into the lines that are provided under "Other techiniques (describe)"

- ☐ Ignore problem behavior
- ☐ Scold child
- ☐ Spank child
- ☐ Threaten child
- ☐ Reason with child
- ☐ Tell child to sit on chair
- ☐ Send child to his or her room
- ☐ Take away some activity or food
- ☐ Redirect child's attention
- ☐ No technique used
- ☐ Other techniques (*describe*): _____

_____

_____

Which disciplinary techniques are usually <u>effective</u> with your child's behavior?

Which disciplinary techniques are usually <u>ineffective</u> for your child's behavior?

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

What are your child's assets aand/or strengths?

THANK YOU FOR TAKING THE TIME TO HELP US GET TO KNOW YOU BETTER

Please use the remaining space on this form to provide Anan & Associates any additional information that you feel would be helpful and/or important for us to know as we work with you through our therapy services: