ASSOCIATED PSYCHOLOGISTS OF SOUTH ORANGE COUNTY

(949)716-5150

CHILDHOOD HISTORY QUESTIONNAIRE

GENERAL INFORMATION

Name: _____ **Date:** _____

Complete Address: _____

Home Phone Number: _____ **Parent's Phone Number:** _____

Birthdate: _____ **Age:** _____ **Height:** _____ **Weight:** _____

SCHOOL INFORMATION

School presently attending: _____ **Current Grade:** _____

Name and position of school personnel who are familiar with your child:

_____

_____

Please list all schools your child has attended:

Name of School	Grades Attended
_____	_____
_____	_____
_____	_____
_____	_____

How does your child seem to be doing in school? _____

_____

What are some things your child likes about school? _____

_____

What are some things your child dislikes about school? _____

_____

How often is your child truant or tardy? _____

Does your child have many friends? _____

INFORMATION ABOUT THE PROBLEM

Please state the nature of your child's problems, including approximately when they began: _____

_____

If you've worked with other professionals in the past, please list their names, as well as the length of time in treatment: _____

_____

Circle any of the following that apply to your child:

Headaches	**Dizziness**	**Fainting Spells**	**Palpitations**	**Stomach Problems**
Overeating	**Fatigue**	**Lack of Appetite**	**Insomnia**	**Bowel Disturbances**
Depression	**Tremors**	**Suicidal Thoughts**	**Panic Attacks**	**Unable to Enjoy Life**
Crying Often	**Shyness**	**Quick to Anger**	**Fights Often**	**Unable to Relax**
Nightmares	**Tension**	**Hyperactivity**	**Loneliness**	**Can't Make Decision**
Aggression	**Bedwetting**	**Head Banging**	**Drug Abuse**	**Can't Make Friends**
Tics/Spasms	**Inferiority**	**Alcohol Abuse**	**Nail Biting**	**Attention Problem**

Other: _____

What are your child's strengths? _____

_____

Siblings

Sibling's Name: _____ **Age:** _____ **School:** _____

Sibling's Name: _____ **Age:** _____ **School:** _____

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Sibling's Name: _____ **Age:** _____ **School:** _____

DEVELOPMENTAL HISTORY

Date and place of birth: _____

If applicable, were pregnancy and delivery normal? _____ **Please list any complications/illnesses:**

_____

_____

Developmental Milestones:	**When did your child begin to:**
Activity	**Age of Onset**
Sit Up	_____
Crawl	_____
Walk	_____
Speak Words	_____
Speak Sentences	_____
Toilet Train	_____
Dress self independently	_____

HEALTH DURING CHILDHOOD

_____

_____

List any accidents, hospitalizations, or surgeries you child has undergone:

_____

When was your child's last physical exam? _____ **What were the results?**

_____

Is your child presently taking medications? _____ **Please indicate type(s) and dosage(s):** _____

_____

INTERESTS

Please list your child's present interests, hobbies, activities, organizations, etc.:

_____

_____

How is most of your child's free time spent? _____

_____

Does your child have their own room? _____

How do they take care of their personal possessions: _____

_____

Does your child get an allowance? Yes _____ **No** _____ **Amount:** _____

Please describe how your child spends their money: _____

Please describe how chores are divided in the family: _____

_____

How do/does your child (or children) get special attention:_____

_____

PARENTAL HISTORY

Are you presently married? Yes _____ **No** _____ **If so, for how long?** _____

Are you currently living with your spouse? Yes _____ **No** _____

How long have you known your spouse/partner? _____

How do you get along with your present in-laws (parents, brothers/sisters in-law?

_____

Have you been married before? Yes _____ **No** _____ **If so, please give details of previous marriages:**

_____

_____

In what areas are you most compatible? _____

_____

In what areas are you least compatible? _____

_____

FAMILY HISTORY

Father's Name: _____ **Occupation:** _____

Age: _____ **Health:** _____ **Education:** _____

Please describe your child's feelings about their father: _____

_____

_____

How much contact does father have with the child? _____

_____

_____

Mother's Name: _____ **Occupation:** _____

Age: _____ **Health:** _____ **Education:** _____

Please describe your child's feelings about their mother: _____

_____

_____

How much contact does mother have with the child? _____

_____

_____

Step-parent's Name: _____ **Education:** _____

Age: _____ **Health:** _____ **Education:** _____

Please describe your child's feelings about their step-parent: _____

_____

_____

What is the typical style of discipline used by the parents/step-parents: _____

_____

Describe your most enjoyable family activities: _____

_____

_____