Karen Klein Villa, Ph.D.
Licensed Psychologist
Psychotherapy, Assessment, and Consultation
1056 Charles Orndorf Dr., Suite B
Brighton, MI 48116
Phone (810) 225-9175 - Fax (810) 225-9555
kkvphd@gmail.com

CHILD BACKGROUND QUESTIONAIRE

Today's Date: _____

Child's name:_____ Gender: M F

Age:_____ Date of Birth:_____ Birthplace:_____

Address:_____ City:_____ Zip:_____

Phone:_____ Religion (optional):_____

Education/grade:_____ School:_____

Name of person completing this form:_____

Relationship to child:_____

Referral Source:_____

Describe the main concerns for which you are seeking psychological services:_____

_____

_____

_____

_____

Has your child received treatment for these concerns in the past? If so, when and by whom? _____

_____

_____

_____

Please list all persons currently living in the home with the child:

Name	Age	Gender M / F	Relationship to Child

Other family members not living in the home with the child:

Name	Age	Gender M / F	Relationship	Reason not at home; when left.

How long has the child been living in the current home?_____

Number of moves in the child's life:_____

If both parents work, who cares for the child?_____

Any major family stresses in the past several years (ie. Death, illness, marital problems, family separation, unemployment, etc)._____

_____

PARENT INFORMATION:

Marital Status:_____

Custody situation:_____

Mother name:_____

___Natural parent ___Step-parent ___Adoptive parent ___Relative

Occupation/Employer:_____

Education (highest level completed):_____ Religion:_____

Age:_____ Birthdate:_____ Birthplace:_____

Father name:_____

___Natural parent ___Step-parent ___Adoptive parent ___Relative

Occupation/Employer:_____

Education (highest level completed):_____ Religion:_____

Age:_____ Birthdate:_____ Birthplace:_____

Other parent:_____

___Natural parent ___Step-parent ___Adoptive parent ___Relative

Occupation/Employer:_____

Education (highest level completed):_____ Religion:_____

Age:_____ Birthdate:_____ Birthplace:_____

Other parent:_____

___Natural parent ___Step-parent ___Adoptive parent ___Relative

Occupation/Employer:_____

Education (highest level completed):_____ Religion:_____

Age:_____ Birthdate:_____ Birthplace:_____

If child is adopted:

Adoption source:_____

Reason/circumstances:_____

Age when child first came home:_____

Date of legal adoption:_____

What has the child been told:_____

Please list anyone in the immediate family with learning difficulties:

Person (parent, brother, sister, grandparent, uncle, etc)	Type of difficulty (language, reading, math, attention, auditory processing, etc)

Please list anyone in the immediate family with behavioral or emotional difficulties:

Person (parent, brother, sister, grandparent, uncle, etc)	Type of difficulty (depression, anxiety, drugs, psychosis, trouble with the law, etc)

BIRTH INFORMATION (to be completed by mother if possible):

List number of: pregnancies:_____ live births:_____ stillbirths:_____

miscarriages:_____ living children:_____deceased children:_____

Did you receive regular medical care during entire pregnancy?_____

Did you smoke during pregnancy? If yes, how many cigarettes per day?_____

Did you drink alcohol during pregnancy? If yes, how much?_____

Did you take any medications during pregnancy? If yes, please list type and amount:_____

_____

Any problems/illnesses during pregnancy (diabetes, bleeding, high blood pressure, etc)? If yes, please explain:_____

_____

Length of pregnancy (full term or number of weeks):_____

Describe your labor, easy, hard, etc._____ How long did labor last?_____

Birth weight (lbs/oz):_____ Type of delivery:_____

Were there any complications during delivery:_____

How long did the baby stay in the hospital?_____

Did the baby require any special care after delivery? If yes, please explain:_____

_____

Other notable information during pregnancy or delivery:_____

_____

DEVELOPMENTAL HISTORY:

Please indicate age at which child:

Sat up		Crawled	
Walked		Spoke single words	
Spoke sentences		was potty trained	

Does the child eat/drink well?_____

Does the child sleep well?_____

Any allergies:_____

List all current medications and dosage:_____

Please list all health problems the child **has had** or **has now**:

√		Age		√		Age
	High fevers				Dental Problems	
	Pneumonia				Weight Problems	
	Flu				Allergies	
	Encephalitis				Skin Problems	
	Meningitis				Asthma	
	Convulsions				Headaches	
	Unconsciousness				Stomach Problems	
	Concussions				Accident Prone	
	Head Injury				Anemia	
	Fainting				High or Low Blood Pressure	
	Dizziness				Sinus Problems	
	Tonsils Out				Heart Problems	
	Vision Problems				Hyperactivity	
	Hearing Problems				Other Illnesses, etc.	
	Earaches					

Has the child ever been hospitalized? If yes, please explain (include age, length of hospital stay, reason, etc.)_____

_____

Has the child ever been evaluated by a psychologist, psychiatrist, or counselor? If yes, please explain (include date, by whom, and why)._____

_____

Other developmental information we should know:_____

_____

EDUCATIONAL HISTORY:

	School	City, State	Dates attended/ Grades completed
Preschool			
Kindergarten			
Elementary			
Elementary			
Middle School			
High School			

Has the child ever repeated a grade? If yes, which grade._____

Has the child ever skipped a grade? If yes, which grade._____

Does the child have an IEP or 504 plan? If yes, why and when was it last updated?_____

_____

Has the child ever received special services at school? If yes, please explain when and why._____

_____

Does the child attend school regularly?_____

Does the child enjoy school?_____

What is the child's usual range of grades (A to C, B to D, etc)?_____

Has the child ever been suspended or expelled? If yes, explain._____

_____

List the child's interests, hobbies, sports, activities, etc., they participate in outside of school:_____

_____

_____

Other educational information we should know._____

_____

Is the child employed? If yes, where, for how long, and how many hours a week do they work? _____

_____

_____

Is there any other information you feel we should know about your child?_____

_____

_____

_____

_____

Signature of parent/guardian:_____

Best method to contact you:_____

Thank you for taking the time to complete this questionnaire. I look forward to working with you.