CHILD AND FAMILY THERAPY ASSOCIATES
CONFIDENTIAL FAMILY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's Name: _____ Sex _____ Age _____ DOB _____

Address: _____

Phone: _____

Father's Name: _____
If not natural father, give relationship: _____
Address (if different from above): _____

Mother's Name: _____
If not natural mother, give relationship; _____
Address (if different from above): _____

If not presently with the child, please give whereabouts of biological father and/ or mother:

Father: _____ Mother: _____
Parents are: _____Married _____ Divorced
_____Separated _____ Living together

Legal Custodian of child, if other than natural parent(s): _____

Referring person or agency: _____
Address: _____

Name(s) of person(s) completing this form: _____
Relationship to child: _____

II. CHILD' CURRENT PROBLEMS AND THEIR HISTORY:

1. Describe the child's current problem(s) (medical, behavioral, emotional).
   a. _____
   b. _____
   c. _____
   d. _____

1. When did the current problem(s) start or when did you first notice it/ them? _____
   _____
   _____

2. What do you think is the cause of the current problem(s)? _____
   _____
   _____

3. Do you feel that the child is aware of the problem(s)? _____no _____yes

If yes, how is this awareness expressed? _____
_____

4. Do mother and father agree on the existence or extent of the problem(s)? _____yes _____no
   If no, please explain: _____
   _____

5. Has the child had problems <u>other than</u> the current one(s)? _____yes _____no
   If yes, please specify: _____
   _____

   What was done about the problems?_____
   _____
   _____

III. <u>CHILD'S EDUCATION</u>

1. School your child is presently attending: _____
   Locations: _____Grade Completed: _____

2. Other school attended by your child and approximate dates of attendance:
   _____
   _____

3. Child's academic strengths: _____
   _____

4. Child's academic weaknesses or problems: _____
   _____

5. Child's behavior problems in school: _____
   _____

6. Please check what you feel best describes your child in the following area:

	Above Average	Average	Below Average
Grades:	_____	_____	_____
Ability:	_____	_____	_____

Attendance:
_____ usually present
_____ often absent with excuse
_____ truant

Relations with peers:
_____ excellent
_____ usually gets along
_____ problems

Relations with teachers _____ excellent
_____ usually gets along
_____ problems
_____with specific teacher
_____with most/ all teachers

7. Has your child ever required special academic help in any of the schools attended? ____yes ____ no. If yes, please specify what kind and give dates.

_____

dates school nature of help

_____

dates school nature of help

8. Has your child repeated any grades? ____yes ____no. If yes, please give details including which grade, reason for repeating grade and whether the results were beneficial or not: _____
_____

9. Has the child been involved with any extra-curricular activities, school-related or otherwise? ____yes ____no. If yes, give details and describe successes and problems: _____
_____

10. What do you feel is the school's attitude toward parents? _____
_____

11. Do you feel that the school is dealing appropriately with your child's strengths? _____yes _____no
Comments: _____

12. Do you feel that the school is dealing appropriately with your child's problems? _____yes _____no

IV. CHILD'S DEVELOPMENT

A. Pregnancy (Place a question mark (?) on the "yes" line if you do not know)

	Yes	No
1. Was this pregnancy:		
Planned?	_____	_____
Desired by mother?	_____	_____
Desired by father?	_____	_____
Of normal duration? If no, give duration: _____ months	_____	_____
	Yes	No
2. Check problems during pregnancy:		
High blood pressure	_____	_____
Low blood pressure	_____	_____
Sugar in urine	_____	_____

Protein in urine	_____	_____
Bleeding or spotting	_____	_____
High fever	_____	_____
Cold blisters on lips	_____	_____
German (3-day) measles	_____	_____
Rh problems	_____	_____
Other problems (specify)	_____	_____

	Yes	No
3. During the course of the pregnancy:		
Did you take any medications?	_____	_____
If yes, what kind and how long? _____		
Did you smoke cigarettes? If yes, How many daily? _____	_____	_____
Did you drink alcoholic beverages?	_____	_____
If yes, give details: _____	_____	_____
_____		
Were you dependent on or taking drugs? If yes, give details ____	_____	_____
_____	_____	_____
Did you have X-rays? If yes, when during pregnancy and how many?	_____	_____
_____		

4. What month in your pregnancy did you start seeing the doctor regularly? _____
_____

B. <u>Delivery</u> (Place a question mark (?) on the "yes" line if you do not know)

1. Name and address of the hospital where child was delivered: _____
_____

	Yes	No
2. Was labor unusually long? If yes, how many hours? _____	_____	_____
3. Was delivery aided by forceps or vacuum?	_____	_____
4. Was your child born by caesarean section?	_____	_____
5. Was more than one baby born?	_____	_____
6. Was child blue at birth?	_____	_____

7. Was child yellow (jaundiced) during 1st week? _____ _____

8. Was your child administered oxygen at birth? _____ _____

9. Was your child placed in an incubator? _____ _____

10. Was anything other than above wrong with baby? If yes give details: _____ _____
_____

Yes No

11. Did the mother have any problems during or immediately after delivery? If yes, give details: _____ _____
_____

12. What was child's weight at birth? _____

13. What was child's length at birth? _____

14. How long did you stay in the hospital? _____

15. How long did your baby stay in the hospital? _____

C. Early Development (Place question mark (?) in the "yes" line if you do not know)

Yes No

1. Was your baby breast fed? _____ _____
If yes, for how long _____

2. Was your baby formula fed? _____ _____

3. How old was your child when he/she:
   a. established eye contact with someone _____
   b. smiled _____
   c. turned over from back to stomach _____
   d. sat alone without support _____
   e. crawled _____
   f. walked without support _____
   g. said first words _____
   h. said first sentence _____
   i. was capable of self-feeding _____
   j. was self-dressing without help _____
   k. was bladder trained during the day _____
   l. was bladder trained during the night _____

m. was bowel trained _____
n. showed fear of strangers _____

4. Were there changes in the child's primary caretakers during the first three years of life?
_____ yes _____ no If yes, how many times? _____
_____

5. Was the child attached to any inanimate objects (e.g. blanket, teddy bear)?
_____ yes _____ no If yes, what object? _____
From age _____ to _____

6. Have there been attempts to change the child's handedness? _____ yes _____ no

7. Is your child (circle answer): right-handed, left-handed, ambidextrous?

8. During the 2nd and 3rd years of life, the child (check):

	Frequently	Sometimes	Rarely
a. had temper tantrums	_____	_____	_____
b. had extreme mood changes	_____	_____	_____
c. was afraid of new faces or places	_____	_____	_____
d. was distractible	_____	_____	_____
e. was unresponsive to discipline	_____	_____	_____
f. was destructive	_____	_____	_____
g. engaged in self-hurting or injuring behavior (rocked or head banged)	_____	_____	_____
h. was very quiet	_____	_____	_____
i. did not like to be held/touched	_____	_____	_____
j. preferred toys to contact with people	_____	_____	_____
k. cried	_____	_____	_____

9. During the first three years of life the child (check):

a. enjoyed being held	_____	_____	_____
b. was alert to what was happening around her/him	_____	_____	_____
c. explored the surrounding environment	_____	_____	_____
d. was active	_____	_____	_____
e. interacted with adults	_____	_____	_____
f. interacted with other children	_____	_____	_____
g. was predictable in terms of sleep-waking patterns	_____	_____	_____
h. was predictable in terms of bowel and bladder patterns	_____	_____	_____
i. was predictable in terms of hunger patterns	_____	_____	_____

10. Sexual Development:

a. Has your child sought any sexual information from parents?
_____ yes _____ no If yes, describe nature of questions and how you handled them:
_____
_____

b. Has your child started developing sexual characteristics?
_____ yes _____ no If yes, age of onset: _____

For girls: date of first menstrual period: _____
Cramps or other physical discomfort: _____ yes _____ no
If yes, please describe: _____
_____
What was her attitude toward menstruation? _____
_____

c. Has onset of puberty appeared to cause any difficulties for your child?
_____ yes _____ no
If yes, give details: _____
_____

d. Has your child ever behaved or talked in a way that was not appropriate for a girl/boy of her/his age? _____ yes _____ no
If yes, give details: _____
Nature of behavior: _____
Age of child at time: _____ Who noticed the behavior? _____
What was done about it? _____

D. CURRENT BEHAVIOR

1. Regarding the child's interactions with others:

	Yes	No	Is it a problem?
a. Is the child usually a loner?	_____	_____	_____
b. Does the child prefer younger children?	_____	_____	_____
c. Does the child prefer older children?	_____	_____	_____
d. Does the child prefer adults?	_____	_____	_____
e. Does the child usually avoid situations in which he/she would be a follower?	_____	_____	_____
f. Does the child usually avoid situations in which he/she would be a leader?	_____	_____	_____
g. Does the child have frequent fights with adults?	_____	_____	_____
h. Does the child have frequent fights with peers?	_____	_____	_____
i. Does the child have frequent fights with siblings?	_____	_____	_____

2. For each of the pairs of opposites below, circle the one number which best describes HOW your child USUALLY APPEARS to you (for example, circling 1 on the first pair would mean your child is usually very happy; circling 4 would mean that he/she is usually somewhat sad):

Happy	1	2	3	4	5	Sad
Withdrawn	5	4	3	2	1	Outgoing
Reflective	1	2	3	4	5	Impulsive
Unconfident	5	4	3	2	1	Confident
Calm	1	2	3	4	5	Nervous
Hostile	5	4	3	2	1	Friendly
Patient	1	2	3	4	5	Frustrated
Changing moods	5	4	3	2	1	Steady moods
Fearless	1	2	3	4	5	Frightened
Hyperactive	5	4	3	2	1	Lethargic
Interested	1	2	3	4	5	Bored
Violent emotions	5	4	3	2	1	Even-tempered
Eats well	1	2	3	4	5	Problem eater
No sense of humor	5	4	3	2	1	Sense of humor
Independent	1	2	3	4	5	Dependent

3. Check the ones your child exhibits NOW:

	Yes	No
a. Fears	_____	_____
b. Much fantasy	_____	_____
c. Much daydreaming	_____	_____
d. Hallucinations (seeing, hearing, smelling, tasting things which do not exist)	_____	_____
e. Disorientation (confused regarding who she/he is, date, time or place)	_____	_____
f. Self-destructive behavior	_____	_____
g. Suicidal thoughts or attempts	_____	_____
h. Nervous habits or tics (e.g. nail biting)	_____	_____
i. Fitful sleeping	_____	_____
j. Nightmares	_____	_____
k. Sleepwalking	_____	_____
l. Poor attention or concentration	_____	_____
m. Difficulty following instructions	_____	_____
n. Difficulty solving problems	_____	_____
o. Poor memory	_____	_____
p. Poor speech articulation	_____	_____
q. Stuttering	_____	_____
r. Compulsive speech (can't seem to stop talking)	_____	_____
s. Loss of memory	_____	_____
t. Repeating words or sentences	_____	_____
u. Repeating (echoing) what others say	_____	_____
v. No speech	_____	_____

	Yes	No
w. Difficulty distinguishing left from right	_____	_____
x. Eating non-food material (pica)	_____	_____
y. Vandalism	_____	_____
z. Fire setting	_____	_____
aa. Verbal aggression	_____	_____
bb. Physical aggression	_____	_____
cc. Cruelty to animals	_____	_____
dd. Lying	_____	_____
ee. Drug use	_____	_____
ff. Stealing	_____	_____
gg. Prefer to be alone	_____	_____
hh. Very shy	_____	_____

4. Describe your child's strengths (with regards to abilities, behaviors, etc.):
   a. _____
   b. _____
   c. _____

V. CHILD'S HEALTH

1. What is your child's current: weight _____ height _____

2. Were there any unusual reactions to any immunizations? _____ yes _____ no

3. Does your child have any allergies? _____ yes _____ no If yes, give details: _____
   _____

4. Has your child ever had a fever above 105? _____ yes _____ no If yes, give the child's age at the time and the cause: _____

5. Has your child had a fever for more than 5 days? _____ yes _____ no If yes, give details: ___
   _____

6. Has your child ever lost consciousness? _____ yes _____ no If yes, give details: _____
   _____

7. Has your child ever had significant accidents or injuries (including broken bones)?
   _____ yes _____ no If yes, give details: _____

   Has your child ever sustained a closed-head injury? _____ yes _____ no If yes, give details:
   _____

9. Has your child ever been hospitalized? _____ yes _____ no If yes, give details: _____
   _____

9. Has your child ever had any operations? _____ yes _____ no If yes, give details: _____
_____

10. Has your child ever had any seizures (convulsions)? _____ yes _____ no If yes, give details:
_____

11. Has your child ever received medications in the past for emotional, physical, learning or behavioral problems? _____ yes _____ no If yes, list medication:

Name: _____ Amount: _____ Date given: _____ to _____
Name: _____ Amount: _____ Date given: _____ to _____
Name: _____ Amount: _____ Date given: _____ to _____

12. Is the child presently taking any medication? _____ yes _____ no If yes, give details:
Problem: _____ Medication: _____
Daily dose: _____ Times per day: _____ Taken since: _____
Who prescribed? _____
Is it helping? _____

13. Does your child currently complain of any of the following symptoms, or has she/he complained of them in the past?

	Yes	No	Age	How treated
Fever	_____	_____	_____	_____
Headache	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____
Double vision	_____	_____	_____	_____
Ringing ears	_____	_____	_____	_____
Shakiness	_____	_____	_____	_____
Trouble swallowing	_____	_____	_____	_____
Near-sightedness	_____	_____	_____	_____
Far-sightedness	_____	_____	_____	_____
Blurred vision	_____	_____	_____	_____
Astigmatism	_____	_____	_____	_____
Crossed eyes	_____	_____	_____	_____
Trouble hearing	_____	_____	_____	_____
Nosebleeds	_____	_____	_____	_____
Constant cough	_____	_____	_____	_____
Shortness of breath	_____	_____	_____	_____
Swollen ankles or hands	_____	_____	_____	_____
Joint or muscle pain/ tenderness	_____	_____	_____	_____
Heart murmur	_____	_____	_____	_____
Vomiting	_____	_____	_____	_____
Loose stools	_____	_____	_____	_____
Hard stools	_____	_____	_____	_____

	Yes	No	Age	How treated
Soiling (bowel movement accidents)	_____	_____	_____	_____
Bed wetting/day wetting	_____	_____	_____	_____
Pus or blood in urine	_____	_____	_____	_____
Pus or blood in stools	_____	_____	_____	_____
Anemia	_____	_____	_____	_____
Muscle weakness	_____	_____	_____	_____
Abnormal posture	_____	_____	_____	_____
Excessive sweating	_____	_____	_____	_____
Poor appetite	_____	_____	_____	_____
Pale skin	_____	_____	_____	_____
Blue skin	_____	_____	_____	_____
Rash	_____	_____	_____	_____
Jaundice	_____	_____	_____	_____
Sore throat	_____	_____	_____	_____
Earache	_____	_____	_____	_____
Passing water frequently	_____	_____	_____	_____
Pain on passing water	_____	_____	_____	_____

Other (describe): _____

14. Family illnesses:
    A. Any physical or emotional health problems?
    Father? _____
    Mother? _____
    Father's side? _____
    Mother's side? _____
    Child's brothers? _____
    Child's sisters? _____

    B. Has the child used alcohol to excess? _____ yes _____ no
    Has the child used other drugs to excess? _____ yes _____ no
    Has the child's father used alcohol or other drugs to excess? _____ yes _____ no
    Has the child's mother used alcohol or other drugs to excess? _____ yes _____ no
    List any persons in your families <u>who have had</u> or <u>who currently have</u> problems with alcohol or drugs. Include the child, his/her brothers or sisters, his/her parents, his/her grandparents, aunts or uncles: _____
    _____
    _____
    _____

VI. PARENT-CHILD RELATIONS

A. Joint Activities

1. What kinds of things do you do together with your child?
   Father: _____
   _____
   Mother: _____
   _____

2. In what joint activities do you engage as a family? _____
   _____
   _____

B. Discipline

1. How do you discipline your child (describe)?
   Father: _____
   Mother: _____
   Other adults in family: _____

2. Are there differences between father and mother with regards to discipline?
   _____ yes _____ no If yes, explain: _____
   _____
   Have these difference been a source of strain for the family? _____ yes _____ no

3. Who usually disciplines the child? _____

4. Does the child prefer one parent over the other? _____ yes _____ no
   If yes, whom? _____

VII. SIGNIFICANT EVENTS

1. Have there been separations for your child from parents?
   Father: _____ yes _____ no If yes, give details including dates: _____
   _____
   _____
   Mother: _____ yes _____ no If yes, give details including dates: _____
   _____
   _____

2. Were the parents nervous, anxious or depressed during the pregnancy with the child?
   Father: _____ yes _____ no If yes, give details: _____
   Mother: _____ yes _____ no If yes, give details: _____

3. Were the parents nervous, anxious or depressed during the child's first year of life?
Father: _____ yes _____ no If yes, give details: _____
Mother: _____ yes _____ no If yes, give details: _____

4. Was either parent unable or unwilling to care for the child at any time?
_____ yes _____ no If yes, details: _____

5. Was this child wanted after she/he was born?
Father: _____ yes _____ no Mother: _____ yes _____ no

6. Has the child suffered the loss of someone very close? _____ yes _____ no
If yes, give details: _____
_____

7. Has the child had any frightening experiences? _____ yes _____ no
If yes, give details: _____
_____

8. Have any of the following events occurred in your family?

Event	Year	Describe
_____Moved to a new place	_____	_____
_____Change of school	_____	_____
_____Serious illness or injury in family	_____	_____
_____Death in family	_____	_____
_____Change in family financial status	_____	_____
_____Promotion	_____	_____
_____Loss of job	_____	_____
_____Mother started working outside home	_____	_____
_____Father started working outside home	_____	_____
_____Divorce or separation	_____	_____
_____Brother or sister leaving home	_____	_____
_____Marriage of brother or sister	_____	_____
_____Difficulties/problems with law	_____	_____
_____Emotional problems/difficulties	_____	_____
_____Other (specify):	_____	_____

VIII. CHILDREN

1. List all children, including those by previous and subsequent marriages, and any deceased children with date of death:

Name	Birth date	Grade or occupation	Living in household?

CHILD AND FAMILY THERAPY ASSOCIATES
CONFIDENTIAL FAMILY QUESTIONNAIRE

2. List relatives or others living in the household:

Name Age Relationship Grade or occupation

_____
_____
_____
_____
_____

3. PARENTS' MARITAL HISTORY

a. Would you describe your marital relationship as:

_____ Smooth _____ With occasional difficulties
_____ Failure _____ With frequent difficulties

b. Describe significant marital problems and how they are viewed by both spouses:
Father: _____
_____
Mother: _____
_____

c. Have you sought outside help with regards to marital problems?
_____ yes _____ no If yes, details: _____
_____

4. PARENTS

a. Father: Birth date: _____ Birthplace: _____
Occupation: _____ Place of employment: _____
_____
Date of marriage: _____ If separated, divorced, widowed or previously married, specify and give dates: _____
_____
Education (highest year you completed): _____
Please describe any problems while you were growing up, particularly in reference to any person and/or family problems: _____
_____
_____
_____
_____
_____
_____
_____

b. Mother: Birth date: _____ Birthplace: _____
Occupation: _____ Place of employment: _____
_____
Date of marriage: _____ If separated, divorced, widowed or previously married, specify and give dates: _____
_____
Education (highest year you completed): _____
Please describe any problems while you were growing up, particularly in reference to any person and/or family problems: _____
_____
_____
_____
_____
_____
_____
_____

c. List all members of parents' families including ages, and whether living (L), deceased (D), married (M), or single (S):

Father's family

Father: _____
Mother: _____
Siblings: _____
_____
_____
_____
_____

Mother's family

Father: _____
Mother: _____
Siblings: _____
_____
_____
_____
_____