MARK PRANGE, PH.D.

CLINICAL PSYCHOLOGY
CHILD AND FAMILY PSYCHOLOGY

The purpose of this questionnaire is to obtain a comprehensive picture of your child's background. Reviewing a child's history is important as it provides a thorough understanding of your child. Should there be any questions you are uncomfortable answering on this form, please discuss them privately with Dr. Prange.

CHILDREN'S HISTORY QUESTIONNAIRE

Child's Name:_____ DOB:_____

Mother's Name:_____ Age:_____

Father's Name:_____ Age:_____

Stepmother's Name:_____Age:_____

Stepfather's Name:_____Age:_____

I. Developmental History

Pregnancy and Delivery

Was the pregnancy planned? _____Yes _____No

Was the child's mother under emotional stress during the pregnancy? ___Yes _____No
If yes, what was stressful?_____

_____

_____

What the pregnancy full term? _____Yes _____No If not, how early (in weeks) was the child born?_____

What was the child's birth weight?_____

What was the child's APGAR score (if known)?_____

Were there any complications associated with the pregnancy and/or delivery? If so, please describe:_____

_____

_____

Motor Development and Speech

If you cannot remember specific times, please indicate whether it was Before or After your child was one year of age:

When did your child walk?_____ Before_____After_____ one year
Say his/her first words?_____ Before_____After_____ one year
Talk in sentences?_____ Before_____After_____ one year
Complete toilet training?_____ Before_____After_____ one year

During your child's first year, were there any difficulties with:

Feeding _____Yes _____No
Sleeping _____Yes _____No
Colic _____Yes _____No
Head banging _____Yes _____No
Excessive rocking ___Yes _____No

Did your child have speech problems?_____Yes _____No If yes, please describe_____

_____

Has your child participated in speech therapy?____Yes _____No

Before age 7, did your child experience any difficulties with:

Nightmares _____Yes _____No
Night terrors _____Yes _____No
Bed wetting _____Yes _____No
Soiling pants _____Yes _____No
Unusual fears _____Yes _____No
Aggression _____Yes _____No
Temper tantrums____Yes _____No
Hyperactivity _____Yes _____No
Impulse control_____Yes _____No
Paying attention_____Yes _____No
Other children_____Yes _____No
No fear _____Yes _____No
Being demanding____Yes _____No
Overly sensitive_____Yes _____No

If yes to any of the above, please describe:_____

_____

_____

Did your child experience any developmental delays? If so, please describe:_____

_____

_____

II. Health

Emotional Health

What concerns do you have about your child's emotional health?_____

_____

_____

Have you sought assistance regarding these or similar issues in the past? _____Yes_____No

If so, therapist's name_____

When did treatment begin?_____ How long did you participate in treatment?_____

Is there a family history of serious psychological problems? _____Yes _____No. If yes, please explain_____

_____

Has your child experimented with alcohol and/or drugs? If so, please explain._____

_____

_____

Any history of abuse or neglect? If so, please describe:

_____

_____

Has your child ever been hospitalized for psychological or psychiatric reasons? If yes, please describe._____

_____

Has your child ever attempted to commit suicide? _____Yes _____No. If yes, please explain_____

_____

Has any member of your family ever attempted to commit suicide? _____Yes _____No. If yes, please explain_____

_____

Has your child experienced a change in schools in the past year? _____Yes _____No

Has your child experienced a move to a new home in the past year? _____Yes _____No

Has your child experienced any change in the family structure such as a parental separation or divorce? _____Yes _____No

Has your child experienced a serious illness? _____Yes _____No If yes, please describe:_____

_____

Has your child experienced a serious illness or injury to a family member or close friend? _____Yes _____No If so, when did this occur? How did your child react?

_____

Have there been deaths in the family or of friends or pets? _____Yes _____No
If so, when did this occur? How did your child react? _____

_____

_____

Have there been other frightening events your child experienced? If so, please describe the events, when they occurred, and how old your child was.

_____

_____

Please circle any of the following that you have observed in your child:

sadness	loss of pleasure	tearfulness	loss of appetite
overeating	insomnia	hopelessness	worthlessness
irritability	angry	decreased activity	indecisiveness
clingy	low energy	low self esteem	poor concentration
fearful	anxious	worries	easily frightened
panicky	nervous	temper tantrums	irritability
restless	muscle tension	hyperactive	impulsive
fidgets	messy	loud	impatient
cannot sit still	disorganized	talks too much	orderly
perfectionistic	detailed	persistent ideas	repetitive behaviors
immature	mean	brags	confused
demanding	destructive	lies	cheats
jealous	tense	self-conscious	suspicious
stubborn	shy	touchy spiteful	argumentative
critical	grandiose	too much sleep	lonely
guilty	social withdrawal	easily distracted	attention seeking
biting	bed wetting	daytime wetting	fear/phobias
bullying	arguing with adults	physical harm to others	excessive exercise
fire starting	social skills problems	teasing others	being teased
running away	cutting self	bullied by others	stuttering
motor tics			

Physical Health

How would you rate your child's overall physical health?

1	2	3	4	5	6	7	8	9
Poor	Not well	Fair	Somewhat Good	Moderately Good	Good	Very Good	Extremely Good	Excellent

Does your child eat a well-balanced diet?_____Yes _____No

Please list typical foods your child eats for:
Breakfast_____
Lunch _____
Dinner_____
Snacks_____

Does your child drink water on a daily basis? _____Yes _____No How much?_____

Does your child drink soda or sugary drinks?_____Yes _____No
If yes, please list type of drinks_____
How often do they drink soda or sugary drinks?_____

How much exercise does your child receive?
_____Sedentary (no exercise)
_____Mild exercise (plays on playground, plays in house)
_____Occasional vigorous exercise (rides bike, team sports)
_____Regular vigorous exercise (team sports, swimming, most days of the week)

Does your child have trouble falling asleep?_____Yes _____No

Does your child wake up at night?_____Yes _____No
If yes, do they have trouble falling back to sleep?___Yes _____No

Does your child wake up feeling rested?____Yes _____No

What is the average number of hours of sleep your child receives?_____

Does your child ever have nightmares?_____Yes _____No

Does your child ever sleep walk? _____Yes _____No

Is your child exposed to second hand smoke? _____Yes _____No
If yes, please describe (ie: car, home)_____

What concerns do you have about your child's physical health?_____

_____

_____

List all current prescribed medications, dosages, and reasons for taking the medication.

Medication	Dose	Reason Taken	How Long Prescribed

Please identify (using an "x") any of the below health issues in your family

Health Issue	Mom	Dad	Siblings	Maternal Grandparent	Paternal Grandparent
Alcoholism					
Autoimmune					
Bipolar Disorder					
Cancer					
Diabetes					
Depression					
Drug Problems					
Heart Disease					
High cholesterol					
Hyperactivity					
Hypertension					
Migraine					
Multiple Sclerosis					
Obesity					
Obsessive - Compulsive					
Osteoporosis					
Panic Attacks					
Schizophrenia					
Seizures					
Stroke					
Tic Disorder					
Thyroid					
Other (specify)					

III. Academic

Where does your child attend school?_____

What grade is your child in?_____How many teachers does your child have?_____

Who is your child's primary teacher?_____

Do you attend Parent-Teacher Conferences? _____Yes _____No

What school events have you attended this school year?_____

What feedback have you received from your child's teachers?_____

_____

_____

Is your child in a regular classroom? _____Yes _____No

Does your child have an Individualized Educational Plan in place? _____Yes _____No If so, please describe the disability and services provided in the IEP. _____

_____

_____

Has your child repeated any grades? _____Yes _____No ? If so, please explain_____

_____

_____

Has there been a family history of Learning Disorders, Attention Deficit Hyperactivity, Emotional or Behavioral difficulties, and/or Neurological Disorders? If so, please describe_____

_____

_____

What are your child's typical grades?_____

_____

What is your child's strong point academically?_____

_____

_____

Are any subjects more difficult than others for your child? If so, please describe._____

_____

_____

Please describe any academic difficulties your child has had at school._____

_____

_____

Please describe any behavioral difficulties your child has had at school.

Do you see these same behavior problems at home? Yes No If so, how do you handle them?

Please describe any disciplinary problems your child has had at school.

Do you see these same discipline problems at home? Yes No If so, how do you handle them?

Please describe any relationship difficulties your child has had at school.

Does your child attend after school programs or enriched learning programs? If so, please describe.

Please describe your child's after school routine, including what time they are picked up.

When does your child do their homework?

Do you help your child with their homework? Yes No

IV. Extracurricular & Community Activities

Describe your child's daily routines.

What does your child do for fun?

What extracurricular activities does your child participate in? ie: sports, music, youth groups

How many days of the week does your child have extracurricular activities? _____

Do you feel your child is too busy with extracurricular activities? _____Yes _____No

V. Relationships

Describe your child's relationship with each parent.

Mother:

Father:

Describe your child's relationship with his/her siblings.

Describe your child's relationships with his/her close friends?

Has your child experienced any problems with peer pressure? If so, please describe

Has your child had any difficulties with his/her friends? If so, please describe

Please describe how your child gets along with other adults?

Please describe any concerns you may have regarding any of your child's relationships (ie: family, friends, school)

VI. BEHAVIOR & ATTENTION CHECKLIST

Person completing this form:_____

Relationship to child: _____

	Not At All True	Just a Little True	Pretty Much True	Very Much True
Often fails to give close attention to details or makes careless mistakes in school work or other activities.	0	1	2	3
Often has difficulty sustaining attention in tasks or play activities.	0	1	2	3
Often does not seem to listen when spoken to directly.	0	1	2	3
Often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand directions).	0	1	2	3
Often has difficulty organizing tasks and activities.	0	1	2	3
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).	0	1	2	3
Often loses things necessary for tasks or activities (ie: toys, school assignments, pencils, books, or tools).	0	1	2	3
Is often easily distracted by extraneous stimuli.	0	1	2	3
Is often forgetful in daily activities.	0	1	2	3
Often fidgets with hands or feet or squirms in seat.	0	1	2	3
Often leaves seat in classroom or other situations in which remaining seated is expected.	0	1	2	3
Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents may be limited to subjective feelings of restlessness).	0	1	2	3
Often has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
Is often "on the go" or often acts as if "driven by a motor".	0	1	2	3
Often talks excessively.	0	1	2	3
Often blurts out answers before questions have been completed.	0	1	2	3
Often has difficulty awaiting turn.	0	1	2	3
Often interrupts or intrudes on other (ie: bursts into conversations or games).	0	1	2	3

At what age did you notice these symptoms?_____

Where do these symptoms occur? Please check all that apply:
Home _____
School _____
Other _____

Have these problems disrupted your child's (check all that apply);
Relationships with other children _____
Relationship with adults _____
School/academics _____

VII. ANXIETY CHECKLIST

Person completing this form:_____

Relationship to child: _____

	Not At All True	Just a Little True	Pretty Much True	Very Much True
Excessive anxiety or worry occurring more days than not for at least 6 months	0	1	2	3
Difficulty controlling worry	0	1	2	3
Restlessness or feeling keyed up or on edge	0	1	2	3
Easily fatigued	0	1	2	3
Difficulty concentrating or mind going blank	0	1	2	3
Irritability	0	1	2	3
Muscle tension	0	1	2	3
Difficulty falling asleep or staying asleep or restless sleep	0	1	2	3
Focus of anxiety and worry is not related to another mental health issue	0	1	2	3
Anxiety, worry, or physical symptoms cause significant distress or impairment in social, school, or other important areas of functioning	0	1	2	3
Anxiety and worry is not due to substance abuse or a general medication condition	0	1	2	3
Palpitations, pounding heart, or accelerated heart rate	0	1	2	3
Sweating	0	1	2	3
Trembling or shaking	0	1	2	3
Sensations of shortness of breath or smothering	0	1	2	3
Feeling of choking	0	1	2	3
Chest pain or discomfort	0	1	2	3
Nausea or abdominal distress	0	1	2	3
Feeling dizzy, unsteady, lightheaded, or faint	0	1	2	3
Feelings of unreality or being detached from oneself	0	1	2	3
Fear of losing control or going crazy	0	1	2	3
Fear of dying	0	1	2	3
Numbness or tingling sensations	0	1	2	3
Chills or hot flushes	0	1	2	3

At what age did you notice these symptoms?_____

Where do these symptoms occur? Please check all that apply:
Home _____
School _____
Other _____

Have these problems disrupted your child's (check all that apply);
Relationships with other children _____
Relationship with adults _____
School/academics _____

VIII. DEPRESSION CHECKLIST

Person completing this form:_____

Relationship to child: _____

	Not At All True	Just a Little True	Pretty Much True	Very Much True
Depressed mood for most of the day for more days than not	0	1	2	3
Poor appetite or overeating	0	1	2	3
Insomnia or hypersomnia	0	1	2	3
Low energy or fatigue	0	1	2	3
Low self esteem	0	1	2	3
Poor concentration	0	1	2	3
Difficulty making decisions	0	1	2	3
Feelings of hopelessness	0	1	2	3
Diminished interest in activities or pleasure	0	1	2	3
Weight loss or weight gain	0	1	2	3
Feelings of worthlessness	0	1	2	3
Tearfulness	0	1	2	3

At what age did you notice these symptoms?_____

Where do these symptoms occur? Please check all that apply:
Home _____
School _____
Other _____

Have these problems disrupted your child's (check all that apply);
Relationships with other children _____
Relationship with adults _____
School/academics _____

IX. Divorced Families

If parents are divorced or in the process of divorcing, please provide the following information:

What is the time sharing arrangement?_____

_____

_____

How does your child respond to the time sharing arrangement?_____

_____

_____

_____

Describe any adverse effects you feel the current time sharing arrangement has on your child.

_____

_____

_____

Do you honor the time sharing arrangement? If not, what stops you from honoring the schedule? _____

_____

_____

Does the opposite parent honor the time sharing arrangement? If not, how so._____

_____

_____

Do you arrive to pick up and return your child on time?_____

Does the opposite parent arrive to pick up and return your child on time?_____

How do you communicate with the opposite parent? _____

_____

_____

_____

How do you and the opposite parent address issues with your child? Do you support the opposite parent's decisions?

Describe how you foster your child's relationship with the opposite parent.

Please share any other information you feel would be helpful.