Children's Resource Group

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Child Questionnaire (Ages 1 1/2 – 5)

Child's Name:	Child's Nickname:	Birth Date:
Person Completing Questionnaire:	Relationship to Patient:	Today's Date:

HOW DID YOU HEAR ABOUT CRG?

(We like to know our referral sources. Please be **specific** in identifying the name of your doctor, friend/family member, school, website, or other source that told you about CRG.)

____

____

FAMILY INFORMATION

Mother's Name: ____

Father's Name: ____

Step-Mother's Name (if applicable): ____

Step-Father's Name (if applicable): ____

Please list the Name and Relationship of additional family members that will be involved in your child's care:

____

____

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Parents are: Date

Married ___ ________

Separated ___ ________

Divorced* ___ ________

Unmarried ___ ________

Widowed ___ ________

*If parents are divorced, please describe current custody and visitation arrangements: _______________

____

Is your child a foster child? _____ Yes _____ No Length of time in your home _______

Is child adopted? _____ Yes _____ No Age at adoption _________________

If a foster child or adopted, has this been discussed with your child? _____ Yes _____ No

Who has legal guardianship of the child? ____

Who provides primary care to the child when parent(s) are at work?______________________________

What is the child's ethnic background/race? ____

What is the child's religious affiliation? ____

Please list all persons presently living in your home:

Name	Sex	Age	Relation to Child	Present or Highest Grade Completed	Occupation

Immediate family members not living in the child's home:

Name	Gender	Age	Relation to Child	Current or Highest Grade Completed	Occupation

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PURPOSE OF EVALUATION

What are your questions or concerns regarding your child?

When did you first become concerned about your child?

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PAST/CURRENT MEDICAL ILLNESSES

Issue	Yes	No	Comments
Has your child ever been hospitalized? If yes, please describe, including child's age.			
Has your child ever had any serious accidents requiring medical care? If yes, please describe, including your child's age (include broken bones).			
Has your child had or currently have any serious or chronic illnesses? Please describe.			
Has your child ever had a seizure or convulsion? If yes, please describe, including child's age.			
Has your child ever had tics (facial movements, eye-blinking, etc.)?			
Does your child have any known allergies? Please describe.			
Do you feel your child has trouble hearing? If yes, please explain.			
Do you feel your child has trouble seeing? If yes, please explain.			
Does your child drool frequently?			
Does your child have trouble chewing and swallowing?			
Are you concerned about your child's eating habits? If yes, please describe.			
Are you concerned about your child's sleep habits? If yes, please describe (trouble falling asleep, not being able to sleep in own room, nightmares, awakenings, snoring, and trouble waking up, etc.).			
Does your child have headaches more than once a week?			
Does your child have stomachaches more than once a week?			
Is your child presently taking any medication? If yes, please list the medications, dosages, by whom it was prescribed and why.			

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BEHAVIOR RATING SCALE

Please rate your child's behaviors for each question using the following scale. Circle the best choice.

1 = Never
2 = Sometimes
3 = Often
4 = Always

		1	2	3	4
1.	Does your child seek your affection?	1	2	3	4
2.	Does your child seem more active than other children their age?	1	2	3	4
3.	Does your child have a hard time calming down once they are upset?	1	2	3	4
4.	Does your child readily make eye contact with you?	1	2	3	4
5.	Does your child readily make eye contact with others?	1	2	3	4
6.	Does your child point to what he wants or needs if he/she does not have the language to request what they want?	1	2	3	4
7.	Does your child enjoy playing other children of the same age?	1	2	3	4
8.	Does your child play with toys in the manner for which they were designed?	1	2	3	4
9.	Does your child play well alone?	1	2	3	4
10.	Does your child play well with others?	1	2	3	4
11.	Does your child ever seem oversensitive to sounds or cover their ears frequently?	1	2	3	4
12.	Does your child engage in imaginary play alone?	1	2	3	4
13.	Does your child engage in imaginary play with others?	1	2	3	4
14.	Does your child stop an activity or behavior when told to stop?	1	2	3	4
15.	Does your child adjust their behavior appropriately from one situation to another?	1	2	3	4
16.	Does your child remain with you in a store or other public place?	1	2	3	4
17.	Does your child seem aware of dangers?	1	2	3	4
18.	Does your child have any unusual behaviors or interests? If so, explain:	1	2	3	4
19.	Does your child readily respond to his/her name?	1	2	3	4
20.	Does your child have rages or meltdowns? If so, explain:	1	2	3	4
21.	Do you fear for your child's safety due to impulsive behaviors? If so, explain:	1	2	3	4

How do you handle tantrums or other disruptive behaviors?

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How does your child entertain him/herself?

Describe your child's interactions with family members.

Describe your child's interactions with peers.

Please describe what you consider to be your child's strengths.

FAMILY HISTORY

Is there family history (child's siblings, parents, grandparents, aunts/uncles, cousins) for any of the following?

Issue	Yes	No	Relation to Child
Seizure disorders			
Learning difficulties			
ADHD/ADD			
Depression			
Bipolar Disorder/Manic Depression			
Suicide or suicide attempts			
Tic disorders			
Anxiety difficulties			
Nervous Breakdown			
Schizophrenia			
Substance use/Alcoholism/ Illegal prescriptions			
Autism/Aspergers/Pervasive Developmental Disorder			
Eating Disorders			
Heart Arrhythmia			
Other medical			

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PREGNANCY AND BIRTH HISTORY

This section is to be completed by the mother of the child, if possible. Please indicate if answered by another person: __________________.

Number of living children ___________

Number of deceased children ___________

This child was the product of pregnancy number ___________

Issue	Yes 1	No 2	Comments
Did you have any health problems during pregnancy with this child (such as infections, high blood pressure, diabetes, bleeding, weight loss, accidents, fever, etc.)? If yes, please describe the problem and the time it occurred during the pregnancy.			
Did you take any medication, smoke, drink, or use drugs during this pregnancy? If yes, please list.			
Was your baby carried less/more than nine months? If yes, please indicate the length of pregnancy.			
Were there any difficulties with delivery? If yes, please describe the problems (such as Cesarean section, slow heart rate, fever, etc.).			
How much did your baby weigh at birth?	_______ pounds, _______ ounces		
Did your baby need any special care during the first few hours/days after delivery? If yes, please describe.			
Did you have any difficulty caring for your child during the first few months of life? If yes, please describe.			

DEVELOPMENTAL HISTORY

Issue	Yes	No	Comments
Was your child's development any faster or slower than that of other children? Please explain.			
At what age did your child sit alone?			
At what age did your child crawl?			
At what age did your child walk alone?			
At what age did your child make sounds?			
At what age did your child say single words?			
At what age did your child combine words?			

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Issue	Yes	No	Comments
Is your child toilet trained? If yes, at what age?			
Does your child have toileting accidents during the day? If yes, how often?			
Does your child have toileting accidents during the night? If yes, how often?			

Please describe your child's **current**:

Sleeping and eating habits:

Separation anxiety:

Self-soothing activities:

Temperament:

Sensitivities to noise, touch, and/or taste:

EDUCATIONAL HISTORY AND INTERVENTIONS

What is the name of your child's preschool/daycare (if applicable)?

Does your child receive special education services (IEP) or receive services through First Steps?

Does your child experience behavioral difficulties at preschool or daycare? If yes, explain:

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Has your child received or been evaluated for any of the following?

Issue	Yes	No	Dates	Where and/or Who
Educational/Psychological testing				
Speech/language therapy				
Physical therapy				
Occupational therapy				
Tutoring				
Counseling/ Psychiatry				
Restrictive Diet Supplements				
Other (please list)				

During the past 12 months, has your family experienced any of the following difficulties?

	Yes	No	Comments
Death of a family member			
Serious illness			
Marital problems			
Unemployment/Financial Trouble			
Abuse (sexual, verbal, physical)			
Neglect/Abandonment			
Other significant events/losses/changes			

Please list your child's current medical providers, mental health providers or tutors:

Name Role

____ _______________________

____ _______________________

____ _______________________

____ _______________________

Thank you. Please bring this completed form to your next CRG appointment.

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