DR. CESTNICK

CHILD BACKGROUND QUESTIONNAIRE

Child's name: ____ Today's date: ____________________________

Birth date: ________________________ Age: __________Sex (circle one): Male Female

Home address: ________________________________City: ________________________Zip Code: ___________

Phone: Home # ____________________Mother's Cell #_________________ Father's Cell # ________________

Mother's Email: __________________________________ Father's Email _______________________________

School:____ Grade: ______ Teacher: ___________________________

I DO / DO NOT (please circle) prefer that Dr. Cestnick contact my child's teacher at this time.

Teacher's Contact Information (if applicable): Email or Phone ____

Pediatrician/Physician: ____

Address of Pediatrician/Physician: ____

Phone of Pediatrician/Physician: ____

Person filling out this form (circle) one: Mother Father Stepmother Stepfather Other (please explain below)

____

Mother's (M) name: ____ (M) Education: __________________________

(M) Occupation: ________________________________ Father's (F) name: ___________________________________

(F) Education: _______________________________________ (F) Occupation: ___________________________________

Stepparent's (SP) name: _____________________________________ (SP) Education: ___________________________

(SP) Occupation: ____________________________ (SP) Phone: _________________ (SP) Email:_________________

Marital status of parents: ____

If parents are separated/divorced, how old was child at time of separation? ____

List all people and pets living in household:

Name	Relationship to Child	Age

If any brothers or sisters living outside of the home, list: ______________________________

____

____

Primary language spoken in the home: ______________________________

Other languages spoken in the home: ______________________________

REASON FOR REFERRAL

Briefly describe your child's presenting problems/difficulties: ______________________________

____

____

How long has this problem been a concern for you? _ ______________________________

When was the problem first noticed?: ______________________________

What seems to help the problem?: ______________________________

What seems to make the problem worse?: ______________________________

Has the child received evaluation or treatment for the current problem or similar problems? Yes _______ No _______

If YES, what type(s) of evaluation(s), when, and by whom: ______________________________

____

____

What are your/the child's strengths? ____

____

____

Any prior diagnosis(es)? ____

Who referred you Dr. Cestnick?: ____

DEVELOPMENTAL HISTORY

CIRCLE/CHECK appropriate answers below:

During pregnancy, was mother on medication? YES / NO If yes, what kind? _ ____________________

During pregnancy, did mother smoke? YES / NO If yes, how many cigarettes each day? _

During pregnancy, did mother drink alcoholic beverages? YES / NO If yes, what did she drink? ______________________

Approximately how much alcohol was consumed each day? ____

During pregnancy, did mother use drugs? YES / NO If yes, what kind? ________________________________

Were forceps used during delivery? YES / NO

Was a Cesarean section performed? YES / NO If yes, for what reason? _____________________

Carried to term? YES / NO ______ If no, at what prenatal age was he/she born?

What was the child's birth weight? ______

Were there any birth defects or complications? Yes ______ No ______ If yes, please describe: ___________________

Were there any feeding problems? Yes _______ No ______If yes, please describe: ____________________________

Were there any sleeping problems? Yes ______ No ______ If yes, please describe: _

As an infant, was the child quiet? Yes ______ No ______

As an infant, did the child like to be held? Yes ______ No ______

As an infant, was the child alert? Yes ______ No ______

Were there any special problems in the growth and development of the child during the first few years? Yes ____ No____ If yes, please describe: ____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to mother	______	Put several words together	______
Rolled over	______	Dressed self	______
Sat alone	______	Became toilet trained	______
Crawled	______	Stayed dry at night	______
Walked alone	______	Fed self	______
Babbled	______	Rode tricycle	______
Spoke first word	______		

MEDICAL HISTORY

Is the child on any medication at this time? YES / NO

If yes, please note types, amounts, and duration of taking varied medications: ____

____

____

Allergies: ____

Place a check next to any illness or condition that your child has had. When you check an item, also note the approximate date
(or age) of the illness.

Check	Illness or condition	Date(s) or age (s)	Check	Illness or condition	Date(s) or Age(s)
_____	Measles	_____________	_____	Dizziness	____________
_____	German measles	_____________	_____	Frequent/severe headaches	______________
_____	Mumps	_____________	_____	Difficulty concentrating	____________
_____	Chicken Pox	_____________	_____	Memory problems	____________
_____	Whooping cough	_____________	_____	Extreme tiredness or	____________

_____	Diphtheria	_____________	_____	weakness	____________
_____	Scarlet fever	_____________	_____	Rheumatic fever	____________
_____	Meningitis	_____________	_____	Epilepsy	____________
______	Encephalitis	_____________	_____	Tuberculosis	____________
_____	High fever	_____________	_____	Bone or joint disease	____________
_____	Convulsions	_____________	_____	Gonorrhea or syphilis	____________
_____	Allergy	_____________	_____	Anemia	____________
_____	Hay fever	_____________	_____	Jaundice/hepatitis	____________
_____	Injuries to head	_____________	_____	Diabetes	____________
_____	Broken bones	_____________	_____	Cancer	____________
_____	Hospitalizations	_____________	_____	High blood pressure	____________
_____	Operations	_____________	_____	Heart disease	____________
_____	Ear problems (disease, infection, injury or impaired		_____	Asthma	____________
_____	hearing)	_____________	_____	Neurological	____________
_____	Tubes for ears?	__________________	______	Bleeding problems	____________
_____	Visual problems	_____________	_____	Eczema or hives	____________
_____	Fainting spells	_____________	_____	Suicide attempt	____________
_____	Loss of consciousness	_____________	_____	Other___________	____________
_____	Paralysis	_____________			

SOCIAL, EMOTIONAL AND BEHAVIORAL HISTORY

CIRCLE/CHECK areas that are of concern for your child:

Attention	Tantrums	Repeats words over and over
Hyperactivity	Clumsy	Holds breath
Impulsive	Blank spells	Daredevil
Gives up easily	Slow to learn	Easily frustrated
Shy/timid	Soils self (day/night)	Wets self (day/night)
Sibling rivalry	Stubborn	Eats poorly

Reading	Nightmares	Coordination
Speech Perception	Separation Anxiety	Aggression toward self or others
Hearing	Sleeping	(explain): ____________________
Articulation	Thumb sucking	Fears (explain): _______________
Language	Rocks back and forth	_____________________________
Vision	Hand flapping	_____________________________
Social Skill (explain):	Repetitive Movements (explain):	Nail biting or other nervous habits:
_________________________	_________________________	(explain) _____________________
_________________________	_________________________	___________________________

Any counseling/psychotherapy now or in past? YES / NO (circle one)

If YES, please state reason for counseling/psychotherapy ____

____

____

____

Duration of therapy, with whom, and was it effective?

____

____

Does your child interact well with other children? Have play dates? ______________________________________

____

Any notable problems with peers or adults? ____

____

____

Has your child ever been suspended from school or daycare for inappropriate behavior? Please explain: _______________

____

____

What are your child's favorite activities?

____

____

____

What activities would your child like engage in more than at present?

____

____

____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child and whether from the maternal (mother) or paternal (father) or step/adoptive family line. Step/adoptive should be elaborated upon if notable contact with those families lending to potential impact upon child.

Check	Condition	Relationship to child	Check	Condition	Relationship to child
_____	Alcoholism	__________	_____	Depression	
_____	Cancer		_____	Learning disability	
_____	Diabetes		_____	ADHD	
_____	Heart trouble		_____	Mental Retardation	
_____	Bipolar Disorder		_____	Anxiety Disorder	
			_____	Other	

____

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____

____

EDUCATIONAL HISTORY

CIRCLE/CHECK academic areas of concern:

Reading Spelling Vocabulary Writing Math Oral Expression

Is your child in a special education class? YES / NO

If yes, what type of class? ____

Has your child been held back in a grade? YES / NO

If yes, what grade and why? ____

Any social or behavioral concerns at school? YES / NO If yes, explain: ____

____

Has your child ever received special tutoring or therapy in school? YES / NO

Is your child on an IEP or 504 (circle which)? YES / NO If yes, for how long? ___________________________________

Please describe IEP or 504 accommodations ____

As a parent, are you pleased or disappointed with the way your child's school has been handling his/her learning struggles? (explain)

____

____

____

OTHER INFORMATION

Has your child ever been in trouble with the law? YES / NO (circle one) If YES, Explain __________________________

____

Have any family members been in trouble with the law? YES / NO (circle one) If YES, Explain __________________________

____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use.

Check	Disciplinary technique	Check	Disciplinary technique
_____	Ignore problem behavior	_____	Tell child to sit on chair
_____	Scold child	_____	Send child to his or her room
_____	Spank child	_____	Take away some activity
_____	Threaten child	_____	Other technique (describe)_____________
_____	Reason with child	_____	Redirect child's interest
_____	Don't use any technique		

Which disciplinary techniques are usually effective? ____

____

With what type of problem(s)? ____

____

Which disciplinary techniques are usually ineffective? ____

With what types of problems? ____

Please use this space for any additional information that would be helpful for me to know when working with your child. Thank you.

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Name: ______________________________ Date: ______________________________

Signature: ______________________________