Robin L. Billings, PhD, PLLC
Michigan Neurodevelopment Center
2150 Butterfield Dr., Ste. 110, Troy, MI 48084
www.mncntr.com • drbillings@mncntr.com
Phone: (248) 935-4085 • Fax: (248) 480-0341

CHILD BACKGROUND QUESTIONNAIRE

FAMILY DATA

Child's name: _____ Today's date: _____

Birth date: _____ Age:_____ Sex (circle one): Male Female

Address: _____ City: _____ Zip Code: _____

School: _____ Grade: _____

Pediatrician/Physician: _____

Person filling out this form (circle one): Mother Father Stepmother Stepfather

Other (please explain) _____

If necessary, I give Dr. Billings permission to call me at the following numbers:

Home Phone# _____ OK to leave a message: Yes No

Work Phone #_____ OK to leave a message: Yes No

Cell Phone(s) #_____OK to leave a message: Yes No

Name of person responsible for the bill: _____ SS# _____

Mother's name: _____ Birth Date: _____ Education: _____

Cell Phone: _____ Email: _____

Occupation: _____ Phone: Home _____ Business: _____

Father's name: _____ Birth Date: _____ Education: _____

Cell Phone: _____ Email: _____

Occupation:_____ Phone: Home _____ Business: _____

Stepparent's name: _____ Birth Date: _____ Education: _____

Cell Phone: _____ Email: _____

Occupation: _____ Phone: Home _____ Business: _____

Marital status of parents: _____

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

List all people living in household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages: _____

_____

Primary language spoken in the home: _____

Other languages spoken in the home: _____

PRESENTING PROBLEM

Briefly describe your child's current difficulties: _____

_____

_____

_____

How long has this problem been of concern to 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, when and with whom? _____

Is the child on any medication at this time? Yes _____ No _____

If yes, please note kind of medication: _____

Who referred you to my office? _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

Check

_____ Has difficulty with speech

_____ Has difficulty with hearing

_____ Has difficulty with language

_____ Has difficulty with vision

_____ Has difficulty with coordination

_____ Prefers to be alone

_____ Does not get along well with brothers and sisters

_____ Is aggressive

_____ Is shy or timid

_____ Is more interested in things (objects) than in people

_____ Engages in behavior that could be dangerous to self or others (describe) _____

_____

_____ Has special fears, habits, or mannerisms (describe) _____

_____ Show daredevil behavior

_____ Gives up easily

_____ Wets bed

_____ Bites nails

Check

_____ Has frequent tantrums

_____ Has frequent nightmares

_____ Has trouble sleeping (describe)_____

_____ Rocks back and forth

_____ Bangs head

_____ Holds breath

_____ Eats poorly

_____ Is stubborn

_____ Has poor bowel control (soils self)

_____ Is much too active

_____ Is clumsy

_____ Has blank spells

_____ Is impulsive

_____ Sucks thumb

_____ Is slow to learn

_____ Other (describe) _____

_____

_____

EDUCATIONAL HISTORY

Place a check next to any educational problem that your child currently exhibits.

Check

_____ Has difficulty with reading

_____ Has difficulty with arithmetic

_____ Has difficulty with spelling

_____ Has difficulty with writing

Check

_____ Has difficulty with other subjects (please list) _____

_____

_____

_____ Does not like school

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? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____

If yes, please describe: _____

DEVELOPMENTAL HISTORY

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? _____

Was the child premature? Yes _____ No _____ If so, by how many months? _____

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	_____		

CHILD'S MEDICAL HISTORY

Current Pediatrician/Physician: _____

Address _____ Phone # _____

Past Pediatrician/Physician: _____

Address _____ Phone # _____

Past Pediatrician/Physician: _____

Address _____ Phone # _____

Allergies: _____

Place a check next to any illness or condition that your child has had and the approximate date (or age) the illness emerged.

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	_____

Check	Illness or condition	Date(s) or age (s)	Check	Illness or condition	Date(s) or Age(s)
_____	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	_____	_____	Asthma	_____
	hearing)	_____	_____	Bleeding problems	_____
_____	Visual problems	_____	_____	Eczema or hives	_____
_____	Fainting spells	_____	_____	Suicide attempt	_____
_____	Loss of consciousness	_____	_____	Other_____	_____
_____	Paralysis	_____			

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.

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	_____
_____	Anxiety Disorder	_____	_____	Other	_____

OTHER INFORMATION

What are your child's favorite activities?

1._____ 2._____ 3._____

4._____ 5._____ 6._____

What activities would your child like to engage in more often than he/she does at present?

1._____ 2._____ 3._____

What activities does your child like least?

1._____ 2._____ 3._____

Has your child ever been in trouble with law? Yes _____ No _____

If yes, please describe briefly:_____

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 or food
_____	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 type of problem(s)? _____

_____

What have you found to be the most satisfactory ways of helping your child? _____

_____

What are your child's assets or strengths? _____

_____

Please use this space for any additional information that would be helpful for me to know when working with your child. Please use the back of this form if you need more space. Thank you.

Signature: _____ Date: _____