Background Information Form
Child and Family Psychology

Child's Name: ___________________________ Gender: ___________________________
Date of Birth: ___________________________ Age: ___________________________

Who currently lives at home with your child?

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Relationship to child</th>
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Does the child have any other siblings/half siblings who live elsewhere? If yes, list name, age and gender:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Custody arrangements (if applicable): _____________________________________________________

What schools has your child attended?

<table>
<thead>
<tr>
<th>Out of home care (e.g. Day Care)</th>
<th>Name of School / Centre</th>
<th>Dates</th>
<th>Grades</th>
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<tbody>
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</tr>
<tr>
<td>Preschool</td>
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<tr>
<td>Primary</td>
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<tr>
<td>High School</td>
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Please describe your child’s strengths:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please describe the concerns you have about your child:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please write down your goals for seeing a Psychologist:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please rate your child’s current functioning in the following areas:

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<thead>
<tr>
<th></th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
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<tbody>
<tr>
<td>Social</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Emotional</td>
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<tr>
<td>Intellectual</td>
<td>☐</td>
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<tr>
<td>Physical</td>
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<tr>
<td>Language</td>
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<tr>
<td>Behavioural</td>
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</table>

Please provide details of any previous assessments that have been carried out (e.g. cognitive assessments, speech pathology assessments, etc.)?

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<tr>
<th>TEST</th>
<th>DATE</th>
<th>RESULTS</th>
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</table>

Please bring the results of any previous testing with you to the initial consultation.
Developmental History:

Were there any complications during the pregnancy (e.g. maternal illness, etc)?
______________________________________________________________________________

Term length:  □ Full    □ Premature ___ (wks)    □ Late ___ (wks)  Birth weight _____

Any complications during birth:  ________________________________________________

Did your child experience any issues after birth (e.g. jaundice, seizures etc)?
______________________________________________________________________________

Describe your child’s temperament as an infant (e.g. placid, active, demanding etc):  __________________________
____________________________________________________________________________________

Did your child experience difficulties in any of the following areas during infancy or early childhood?:

☐ Social          ☐ Physical Development        ☐ Cognitive Development
☐ Emotional       ☐ Behavioural                 ☐ Toilet Training
☐ Difficulty with separation  ☐ Sleeping     ☐ Eating

Details:  ________________________________________________________________
______________________________________________________________________________

At approximately what age were the following milestones achieved:

Sitting:  ___________  Crawling:  ________  Walking:  _________  Talking:  __________

List any significant or traumatic events that occurred during infancy or early childhood (e.g. birth of sibling, death of family member, physical or sexual abuse, separation from parent, divorce etc):
____________________________________________________________________________________
______________________________________________________________________________

Primary School Years:

List any difficulties during this time (e.g. social, emotional, behavioural, physical and cognitive development, difficulties starting school, or difficulties with separation)
____________________________________________________________________________________
______________________________________________________________________________

__________________________________________


High School Years:
List any difficulties during this time (e.g. difficulty transitioning to high school, difficulties with relationships with peers, parents or teachers, bullying, issues with academic performance, etc)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Has your child received any special education assistance? □ Yes □ No
If yes, please provide details:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Medical History
Does your child have any current medical conditions, illnesses or allergies? □ Yes □ No
Details: ______________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Has your child’s hearing been tested? □ Yes □ No Were any issues identified: □ Yes □ No
Details: ______________________________________________________________________

Has your child’s vision been tested? □ Yes □ No Were any issues identified: □ Yes □ No
Details: ______________________________________________________________________

Current medications your child takes (please list all):

<table>
<thead>
<tr>
<th>Name or type of medicine</th>
<th>Dose</th>
<th>Frequency</th>
<th>Who prescribes this medication</th>
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<tr>
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<td>4</td>
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</table>
Has your child previously experienced any serious injuries, illnesses, or surgery?  □ Yes  □ No

If yes, provide details and approximate dates: ______________________________________________________________


Family History

Is there any family history of psychological, developmental or learning difficulties?  □ Yes  □ No

If yes, please provide details:

____________________________________________________________

____________________________________________________________________________________

Psychological Treatment History

Has your child previously consulted a professional for any emotional or behavioural issues?  □ Yes  □ No

If yes, please provide details:

____________________________________________________________

____________________________________________________________________________________

Social Functioning

How does your child spend his/her free time? ______________________________________________________________

____________________________________________________________________________________

What type of playmates does your child prefer (tick all that apply):

□ Older  □ Younger  □ Own age  □ All ages  □ Adults

How many friends does your child have?  ______________________________________________________________

____________________________________________________________________________________

Does your child have a best friend?  □ Yes  □ No.  If yes, how long have they been friends: __________

Does your child have trouble making or keeping friends?  □ Yes  □ No

If yes, please provide details: ______________________________________________________________

____________________________________________________________________________________
Perceptions of the Issues
What do you think is contributing to your child’s current presenting problems (e.g. recent change of school, etc.)?
____________________________________________________________________________________
____________________________________________________________________________________
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Please provide information about anything else that you think is important regarding your child
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
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____________________________________________________________________________________

Is there any sensitive information that you would prefer not to discuss in front of your child?

□ Yes   □ No
If yes, we can discuss these issues while your child waits outside. You may wish to bring a book or something for them to do while they wait.

Thank you for taking the time to complete this questionnaire.

Completed by: _______________________________ Date: _____________________