Background Information Form  
Neuropsychology and Clinical 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>
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<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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<tr>
<td>Preschool</td>
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<td>Primary</td>
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<tr>
<td>High School</td>
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</table>
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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<tr>
<th></th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
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<td>Physical</td>
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<td>Language</td>
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<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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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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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.)?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Please provide information about anything else that you think is important regarding your child


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: ________________