

Integrated Clinic for Behavior and Learning Evaluation
 College of Professional Education
 Human Development Building 114
 Texas Woman's University
 Denton, Texas 76204

ASSESSMENT QUESTIONNAIRE-CHILD AND ADOLESCENT

FAMILY DATA

Client's Name _____ Today's Date _____

Birthdate _____ Age _____ Gender (circle one) M F

Vision correction (circle all that apply): Glasses Contacts None

Handedness (circle one): Right Left Ambidextrous

Dominant language: _____

Home Address: _____ Phone: _____

School: _____ Grade: _____

What testing has been completed for this child by school personnel? _____

Person completing this form (circle one): Self Mother Father Stepmother Stepfather

Guardian _____ Other (specify): _____

 Signature(s) of parent(s) or guardian completing this form.

 Printed name of person signing this form

Mother/Guardian: _____ Age _____ Education _____

Occupation: _____ Home Phone _____ Work Phone _____

Father/Guardian: _____ Age _____ Education _____

Occupation: _____ Home Phone _____ Work Phone _____

Marital Status of Parents: _____

If parents are separated or divorced, how old was the child when the separation occurred?

List all the people living in the same household with the child:

Name	Relationship to Client	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/REFERRAL QUESTION

Briefly describe your child's/your 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 any evaluation or treatment for the current problem been provided? (Circle one) Yes No

If yes, when and with whom? _____

Has any medication been prescribed? (Circle one) Yes No

If yes, list all medication currently taken including over-the-counter and herbals, the dosage, and frequency taken.

Who referred your child/you for an evaluation? _____

Have there been any major changes in the client's life over the past few months? If so, explain

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? (Circle one) Yes No

If yes, what kind? _____

During pregnancy, did mother smoke? (Circle one) Yes No

If yes, how many cigarettes a day? _____

During pregnancy, did mother drink alcoholic beverages? (Circle one) Yes No

If yes, what did she drink? _____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? (Circle one) Yes No

If yes, what kind? _____

Were forceps used during delivery? (Circle one) Yes No

Was a Caesarean section performed? (Circle one) Yes No

If yes, for what reason? _____

Was the child premature? (Circle one) Yes No

If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? (Circle one) Yes No

If yes, please describe. _____

Were there any feeding problems? (Circle one) Yes No

If yes, please describe. _____

Were there any sleeping problems? (Circle one) Yes No

If yes, please describe. _____

As an infant, was this child quiet? (Circle one) Yes No

As an infant, did this child cry when held? (Circle one) Yes No

As an infant, was the child alert? (Circle one) Yes No

Were there any special problems in the growth and development of the child during the first few years? (Circle one) 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.

<i>Behavior</i>	<i>Age</i>	<i>Behavior</i>	<i>Age</i>
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	_____	Eye contact with adults	_____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of your immediate family has had. When you check an item, please note the member's relationship to the child.

✓	Condition	Relationship	✓	Condition	Relationship
___	Alcoholism	_____	___	Nervous or psychological problems	_____
___	Cancer	_____	___	Depression	_____
___	Diabetes	_____	___	Learning disability	_____
___	ADHD	_____	___	Heart Trouble	_____
___	Dyslexia	_____	___	Other: _____	_____

CHILD'S MEDICAL HISTORY

✓	Illness / Condition	Dates /Age	✓	Illness / Condition	Dates / Age
___	Measles	_____	___	Dizziness	_____
___	German Measles	_____	___	Frequent or severe headaches	_____
___	Mumps	_____	___	Difficulty concentrating	_____
___	Chicken Pox	_____	___	Memory problems	_____
___	Whooping cough	_____	___	Extreme tiredness /weakness	_____
___	Diphtheria	_____	___	Rheumatic fever	_____
✓	Illness / Condition	Dates /Age	✓	Illness / Condition	Dates / Age
___	Scarlet fever	_____	___	Epilepsy	_____
___	Meningitis	_____	___	Tuberculosis	_____
___	High fever	_____	___	Bone or joint disease	_____
___	Convulsions	_____	___	Allergies	_____
___	Asthma	_____	___	Hayfever	_____
___	Injuries to head	_____	___	Anemia	_____
___	Broken Bones	_____	___	Jaundice / hepatitis	_____
___	Hospitalizations	_____	___	Diabetes	_____
___	Operations	_____	___	Cancer	_____
___	Visual problems	_____	___	Bleeding problems	_____
___	Fainting spells	_____	___	Eczema or hives	_____
___	Loss of consciousness	_____	___	Paralysis	_____
___	Ear problems: (disease, infection, injury,, or hearing impairment	_____	___	High blood pressure	_____

EDUCATIONAL HISTORY

Place a check next to any educational problem that your child / you currently exhibit.

- | | |
|---|--|
| <p>✓</p> <p><input type="checkbox"/> Has difficulty with reading</p> <p><input type="checkbox"/> Has difficulty with math</p> <p><input type="checkbox"/> Has difficulty with spelling</p> <p><input type="checkbox"/> Has difficulty with writing</p> <p><input type="checkbox"/> Has difficulty following oral directions</p> <p><input type="checkbox"/> Has difficulty with tests</p> | <p>✓</p> <p><input type="checkbox"/> Has difficulty with other subjects</p> <p>Please list: _____</p> <p>_____</p> <p><input type="checkbox"/> Does not like school</p> <p><input type="checkbox"/> Has difficulty expressing self</p> <p><input type="checkbox"/> Has difficulty following lectures</p> |
|---|--|

Is your child ever been in special education? (Circle one) Yes No

If yes, what type of class? _____

When? _____

Where? _____

Currently served? _____

Has your child ever been held back a grade? (Circle one) Yes No

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? (Circle one) Yes No

If yes, please describe: _____

Has your child ever failed the TAAS or TAKS? (Circle one) Yes No NA

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?

1. _____ 2. _____ 3. _____

What activities would your child like the least?

1. _____ 2. _____ 3. _____

Has your child ever been in trouble with the law? (Circle one) 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.

<input checked="" type="checkbox"/> <i>Disciplinary Technique</i>	<input checked="" type="checkbox"/> <i>Disciplinary Technique</i>
<input type="checkbox"/> Ignore problem behavior	<input type="checkbox"/> Tell child to sit on chair
<input type="checkbox"/> Scold child	<input type="checkbox"/> Send child to his or her room
<input type="checkbox"/> Spank child	<input type="checkbox"/> Take away some activity or food
<input type="checkbox"/> Threaten child	<input type="checkbox"/> Other technique: (describe)
<input type="checkbox"/> Redirect child's interest	_____
<input type="checkbox"/> Don't use any technique	_____

Which disciplinary techniques are usually effective? _____

Which disciplinary techniques are usually ineffective? _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem your child is currently exhibiting.

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Has difficulty with speech	<input type="checkbox"/> Has frequent tantrums
<input type="checkbox"/> Has difficulty hearing	<input type="checkbox"/> Has frequent nightmares
<input type="checkbox"/> Has difficulty with language	<input type="checkbox"/> Has trouble sleeping (describe)
<input type="checkbox"/> Has difficulty with vision	_____
<input type="checkbox"/> Has difficulty with coordination	<input type="checkbox"/> Rocks back and forth
<input type="checkbox"/> Prefers to play alone	<input type="checkbox"/> Bangs head

- ___ Does not get along well with siblings
- ___ Is aggressive
- ___ Is shy or timid
- ___ Is more interested in objects than people
- ___ Engages in behavior that could be dangerous to self or others (describe) _____
- _____

- ___ Has special fears, habits, or mannerisms (Describe) _____
- _____

- ___ Wets bed
- ___ Bites nails
- ___ Sucks thumb
- ___ Other: _____ (Describe) _____
- _____

- ___ Holds breath
- ___ Eats poorly
- ___ Is stubborn
- ___ Has poor bowel control (soils self)
- ___ Is much too active (describe) _____
- _____

- ___ Is clumsy
- ___ Has blank spells

- ___ Is impulsive
- ___ Shows daredevil behavior
- ___ Gives up easily
- ___ Other: _____ (Describe) _____
- _____