Joseph Edwards, Psy.D. PLLC
Child, Adolescent & Family Psychology
Licensed Psychologist

The Family History Questionnaire

This questionnaire concerns you and your child. I am asking you to complete this questionnaire to assist me in focusing on the concerns you have, and to better understand your child. Some of the information requested may not seem related to your child and his/her problems, but often such seemingly unrelated information becomes very important in my understanding your questions. You may not immediately remember the answers to all of the questions. However, I would appreciate your trying to complete the questionnaire as accurately and completely as possible. Family members, baby books, and close friends etc., can be good resources in completing this questionnaire. If you run out of space in answering a question, feel free to attach a sheet of paper. Your completion of this questionnaire **will help reduce the time needed to make an accurate evaluation of your child's difficulties** as well as help to focus my attention to your specific concerns. If you do not understand any of the questions please feel free to call me at the number listed below.

1300 Clear Springs Trace, Suite 7 ■ Louisville, KY 40223-3868 ■ 502.425.5422 ■ Fax502.425.5424

Today's date: _____

Child's First Name:_____ **Middle:**_____ **Last:**_____

Birthdate:_____ Current Age:_____ Gender: Male ☐ Female ☐ Non-Binary ☐

Grade: _____ School: _____

Child's Primary Home address:_____

_____
City State Zip Code

Child's Cellular Phone: _____ Child's Email: _____

Mother's Name (First, Middle Initial & Last): _____

Mothers's Primary Home address:_____

_____
City State Zip Code

Birthdate: _____ Age: _____
Relationship to child: (check one) Biological ☐ Adoptive ☐ Stepmother ☐ Other ☐

Occupation: _____ Religion: _____
Ethnic Background: _____ Place of Birth: _____
Years in School: _____ Date of this marriage: _____
Place employed: _____ Years with Employers: _____
Work Hours: _____ Work Phone: _____
Cellular Phone: _____ E-Mail: _____

Father's Name (First, Middle Initial & Last): _____

Father's Primary Home address:_____

_____
City State Zip Code

Birthdate: _____ Age: _____
Relationship to child: (check one) Biological ☐ Adoptive ☐ Stepfather ☐ Other ☐

Occupation: _____ Religion: _____
Ethnic Background: _____ Place of Birth: _____
Years in School: _____ Date of this marriage: _____
Place employed: _____ Years with Employers: _____
Work Hours: _____ Work Phone: _____
Cellular Phone: _____ E-Mail: _____

Who referred you to me? _____

What is it that concerns you most about your child? What problems are you having?

When did these concerns begin? _____

Describe what you have tried to do about these problems:

In what other ways do you think your child can best be helped?

In what ways are these problems affecting yourself, other family members or your family as a whole?

Prenatal/Birth History

Did you have problems getting pregnant? _____
Was this a planned pregnancy? Yes ☐ No ☐ How did you feel about it? _____
During which month did you start prenatal care? _____
Did you take any medications during pregnancy (includes all medications, vitamins, birth control pills, etc.)

_____
Did you smoke during pregnancy? Yes ☐ No ☐ If so, when? _____
How many cigarettes a day? _____
How much alcohol did you consume during your pregnancy? Yes ☐ No ☐
Number of drinks a week: _____
Any drug use during the pregnancy? Yes ☐ No ☐
List drug(s): _____
Any illnesses during the pregnancy?

_____
The baby was born: (check one) on time ☐ early* ☐ late* ☐ *By how many weeks? _____
Length of labor in hours: _____
Type of delivery: (check all that apply) Vaginal ☐ Breech ☐ Cesarean ☐ Forceps ☐
Baby's birth weight _____ Length _____ APGAR scores _____ (1-10)
Infant's condition: (check all that apply) Breathed immediately ☐ Cried immediately ☐ Required oxygen ☐
Had Seizures ☐ Required Intensive Care ☐

Problems during the first week of life: (check any that apply) Incubator ☐ Yellow skin ☐
Bleeding ☐ Infection ☐ Special concerns: _____

Developmental History

As an infant/toddler did the child eat well? _____

As an infant/toddler, what was your child's sleep pattern? _____

Please indicate the age in months when your child first did each of the following.
If your child has not yet done it please write "No"; if you do not remember, write "DR".

Held head erect _____
Crawled _____
Stood alone _____
Walked holding on furniture _____
Walked without holding on _____
Ran with good control _____
Walked up steps _____
Rode a tricycle _____
Said "mama" or "dada" _____
Started toilet training _____
Put on clothes _____
Sat alone _____
Pulled to stand _____
Smiled spontaneously _____
Feed self cracker _____
Drank from a cup _____
Played peek-a-boo _____
Recognized parents _____
Showed fear with strangers _____
Spoke in three word sentences _____
Ended toilet training _____
Handedness (check one): left ☐ right ☐ both ☐

Child's Health/Medical History

Please list the name & address of child's physician:

_____
Does your child see any additional physicians/specialists? If yes, please note name and why:

_____
Does the physician know your child well? ☐ yes ☐ no
Does your child take any medication? ☐ yes ☐ no
If yes, please list current medications with the dosage and schedule taken:

Medication	Dosage	Schedule	Approximate Date started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When was your child's last physical exam? _____

Please list any other physicians that your child sees regularly and why:

_____

Child's current height and weight (approximate): Height _____ Weight _____

Please mark what childhood diseases your child has contracted: (LIST AGE)

Mumps _____ Age: _____ 3-day measles _____ Age: _____
Chicken pox _____ Age: _____ 7-day measles _____ Age: _____
Roseola _____ Age: _____ Scarlet fever _____ Age: _____
Whooping cough _____ Age: _____ Serious illnesses: _____ Age: _____
List any unusual complications: _____
Is your child up to date with his/her immunizations? __☐__ yes _☐__ no

Please **mark if** your child has had any of the following:
Accidents: _____
High fever, unknown cause: _____
Pneumonia: _____
Anemia: _____
Lead poisoning: _____
Urine infection: _____
Bowel disease: _____
Problem in bladder or bowel control: _____
Vision problems: _____
If yes, do he/she wear corrective lens? Yes ☐ No ☐
When was the last eye exam?: _____
Hearing: _____
Frequent ear infections: _____
Speech/Language problems: _____
Difficulties eating or feeding self: _____
Difficulties in: Swallowing ☐ Chewing ☐ Drooling ☐
Foot problems: _____
Motor problems: _____
Skin abnormalities: _____
Allergies: _____
Seizures or convulsions: _____
Sleep difficulties: _____
Unusual fears: _____
Unusual behaviors: _____
Ingestion of drugs, cleaners or non-food items: _____
Other illnesses/problems:

_____
Has the child even been hospitalized? (Name of hospital, date & reason for hospitalization):

_____
Has your child ever received any previous psychotherapy or counseling? ☐Yes ☐ No

If yes, describe reason and estimate length of treatment:

_____
With whom & for how long?

_____
What was the outcome of that treatment experience?

_____

School History

Has your child ever been in preschool? ☐ yes ☐ no
If yes, please list where and at what age:

In order of attendance, list all of the schools your child has attended since Kindergarten:

School	Location (if out of town)	Grade Level	Years	Grades—A's, B's, C's, D's U's

Has your child ever been held back a grade in school? Yes ☐ No ☐ If yes, list Grade: _____
Has there ever been a problem in getting your child to go to school? Yes ☐ No ☐
Has your child ever been in special education? Yes ☐ No ☐ If yes, when, where, what kind:

Has your child had remedial classes or tutoring? Yes ☐ No ☐ If so when, where, what kind:

Has your child ever had psychological or psycho-educational testing? Yes ☐ No ☐
If yes, by whom and at what age was he or she assessed?

Has your child ever been diagnosed with having a learning disability? ☐ yes ☐ no
If yes, describe: _____
Was he/she placed in a special classroom or program? _____
Does your child receive special accommodations or services at school? ☐ yes ☐ no
If yes, describe: _____

If your child has a 504 Plan or an Individual Education Plan (IEP), please note what is targeted:
(e.g., Since 2nd grade Dxed with ADHD symptoms, therefore receives extend time when taking quizzes or tests, cueing to stay focused; LD—Reading Disorder/Dyslexia and receives 60 minutes a day of reading tutoring at school/ or privately at The Center for Reading)

Has your child ever received any special services for speech/language, hearing or occupational therapy? Yes ☐ No ☐ If yes, describe:

What is your child's attitude toward school? _____
What are your child's current grades like? _____
How do these grades compare with his/her grades one year ago? _____
Other comments about school:

_____

Social Behavior & Activities

How does your child play and/or get along with other children at
At school _____
In the neighborhood _____
With siblings _____

What things does your child like to do?

_____
What do you consider to be some of your child's strengths?

_____

Describe your child's personality:

_____

What things/activities present the greatest difficulty for your child?

_____
What are your concerns about your child's social functioning?

_____

Family History

Please list all immediate family members (indicate if adopted, half or step-members)

Name	Age	Relationship	Living Where	Siblings- Current School/Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Marriages:	Name	Date married	Date Separated	Date of Divorce	Reason for Divorce
Mother:	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Father:	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Are there any particular family stresses of which you are aware that may have a bearing on your child's problem? If yes, please describe:

_____

Who currently lives in the home?_____

Has your child ever been separated from the family? ☐ yes ☐ no
If yes, list age, duration and reason

_____

If either parent has been married previously, and this child is not the natural child of one of the parents, please give information regarding the absent natural parent:

Name: _____ Age: _____
Address: _____
Phone: _____
Date of separation: _____ Date of divorce: _____
Reason for divorce: _____
What type of custody arrangement was granted by the court? _____
(e.g., Joint Custody, Solo Custody, etc.)
What is the nature & frequency of your child's contacts with the absent parent? Please note the visitation schedule and how regular the schedule is followed:

_____

What difficulties, if any, do any of the other children in the family have?

_____

List any concerns that you have regarding your family's current functioning?

_____

Substance Abuse History

Do you have any concern or suspicion that your child is or ever has experimented with alcohol or drugs? Yes ☐ No ☐
If yes, level of concern: ☐ Little ☐ Moderate ☐ High
Known experimentation or usage? ☐ yes ☐ no
Explain, if yes, on the next page (when did this occur, elaborate on details and name specific drugs):

_____

Family Medical/Family Psychiatric History

Please indicate whether there are any relatives of your child (including parents, grandparents, aunts, uncles and cousins), who have (or have had in the past) the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses or abnormalities such as birth defects, miscarriages, diabetes, seizures or epilepsy, mental or emotional disorders, substance abuse problems, slow development, mental retardation, school problems, cerebral palsy, muscular disorders, cancers, leukemia, thyroid disease, deafness or blindness, speech or language problems, reading or learning disabilities. (Please be as specific as possible, giving **relationship to the child, age of relative and problem**).

Mother_____
Mother's mother_____
Mother's father_____
Mother's brothers & sisters_____
Mother's maternal grandmother_____
Mother's maternal grandfather_____
Mother's paternal grandmother_____
Mother's paternal grandfather_____
Mother's aunts & uncles_____
Mother's cousins_____
Father_____
Father's mother_____
Father's father_____
Father's brothers & sisters_____
Father's maternal grandmother_____
Father's maternal grandfather_____
Father's paternal grandmother_____
Father's paternal grandfather_____
Father's aunts & uncles_____
Father's cousins_____

If you would like to provide any additional information, which you feel would be important for understanding your child and your particular concerns, please use the space below or on the back side of this sheet.

Rev. 4/20