EMPOWER ASSESSMENTS, LLC
BACKGROUND QUESTIONNAIRE

CLIENT NAME _____

DATE OF BIRTH _____ AGE _____

PARENT'S NAME _____ PARENT'S NAME _____

ADDRESS _____ ADDRESS _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

EMAIL _____ EMAIL _____

DATES OF EVALUATION _____

PERSON WHO REFERRED CHILD FOR EVALUATION _____

CHILD'S PEDIATRICIAN _____

REASON FOR REFERRAL (CHIEF PROBLEM) _____

_____

_____

_____

OTHER AREAS OF CONCERN _____

_____

WHAT ARE YOUR CHILD'S STRENGTHS? _____

_____

_____

WHAT ARE YOUR CHILD'S WEAKNESSES? _____

_____

_____

DO YOU HAVE ANY IDEAS ABOUT WHAT MIGHT BE CAUSING YOUR CHILD'S DIFFICULTIES?

_____

HAS YOUR CHILD HAD ANY DIRECT CONTACT WITH A MENTAL HEALTH PROFESSIONAL (PSYCHOLOGIST, PSYCHIATRIST, CLINICAL SOCIAL WORKER) OR ANY OTHER PROFESSIONAL (SPEECH AND LANGUAGE PATHOLOGIST, OCCUPATIONAL THERAPIST, ACADEMIC TUTOR)?

NAME	TYPE OF PROFESSIONAL	DATES OF INVOLVEMENT

HAS PSYCHOLOGICAL OR SPEECH/LANGUAGE TESTING BEEN DONE PREVIOUSLY? IF YES, WHEN AND BY WHOM _____

_____

CURRENT FAMILY SITUATION

WITH WHOM DOES YOUR CHILD SPEND THE MOST TIME? _____

GET ALONG BEST? _____

ARE THERE SIGNIFICANT CONFLICTS BETWEEN CHILD AND PARENTS? _____

_____

HOW DOES YOUR CHILD RESPOND TO DISCIPLINE? _____

_____

DO PARENTS AGREE ON HOW TO DISCIPLINE? _____

_____

WHO DISCIPLINES AND HOW? _____

_____

IS YOUR CHILD FREQUENTLY A SOURCE OF PARENTAL ARGUMENTS?

_____

SCHOOL HISTORY

CURRENT SCHOOL _____

TEACHER(S) OR OTHER SCHOOL PERSONNEL INVOLVED WITH YOUR CHILD:

_____

WHEN DID YOUR CHILD FIRST HAVE DIFFICULTY IN SCHOOL? PLEASE EXPLAIN.

_____

_____

HAS THE SCHOOL REPORTED PROBLEMS WITH (CHECK ALL THAT APPLY):

READING?
WRITING?
MATH?
BEHAVIOR?
OUTPUT OR WORD PRODUCTION?
ATTENTION/CONCENTRATION?
SOCIAL ADJUSTMENT?

DOES YOUR CHILD HAVE A 504 PLAN OR AN IEP? _____
DOES YOUR CHILD RECEIVE SUPPORT SERVICES IN SCHOOL SUCH AS OT, SPEECH/LANGUAGE THERAPY, OR SPECIAL ACCOMMODATONS? _____

_____

SCHOOLS ATTENDED:

NAME	CITY	GRADE(S)

PREGNANCY , LABOR, AND DELIVERY

AGE OF MOTHER AT DELIVERY ____ AGE OF FATHER AT DELIVERY ____
HEALTH PROBLEMS (IF ANY) OF MOTHER DURING PREGNANCY

_____

_____

LENGTH OF PREGNANCY _____
ANY DRUG OR ALCOHOL USE? _____
WAS LABOR (CHECK ALL THAT APPLY)
___ SPONTANEOUS ___ INDUCED ___ VAGINAL ___ C-SECTION
BIRTH WEIGHT OF BABY: _____ POUNDS ____ OUNCES

ANY DIFFICULTIES IN LABOR OR DELIVERY? _____

_____

AGE OF THE BABY AT THE TIME OF HOSPITAL DISCHARGE _____

ANY TROUBLE WITH THE BABY'S FIRST WEEK OF LIFE? _____

_____

ANY PROBLEMS DURING THE FIRST MONTH THE BABY WAS HOME? _____

HOW WOULD YOU DESCRIBE YOUR CHILD'S BASIC TEMPERAMENT OR PERSONALITY DURING THE FIRST YEAR OF LIFE? (E.G., EASY GOING, FUSSY)

_____

_____

DID YOUR CHILD JOIN THE FAMILY THROUGH ADOPTION? ___ YES ___NO

IF YES, PLEASE ANSWER THE FOLLOWING:

A) ___DOMESTIC ___ INTERNATIONAL FROM WHAT COUNTRY? _____

B) CHILD'S AGE WHEN ADOPTED:

C) CHILD'S PLACEMENT PRIOR TO ADOPTION: _____

MEDICAL HISTORY

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES?

ILLNESS	WHEN	FOR HOW LONG

HAS YOUR CHILD EVER BEEN HOSPITALIZED?

WHY	WHEN	FOR HOW LONG

HAS YOUR CHILD EVER HAD ANY OPERATIONS?

_____

_____

HAS YOUR CHILD HAD SEIZURES/CONVULSIONS? ___ YES ___ NO

WERE THEY ASSOCIATED WITH HIGH FEVER? ___ YES ___ NO

DOES YOUR CHILD HAVE : ___ ALLERGIES ___ ASTHMA

HAS YOUR CHILD HAD ANY HEAD INJURIES? IF YES, WHAT HAPPENED? ANY DIZZINESS OR LOSS OF CONSCIOUSNESS?

_____

_____

ANY LOSS OF CONSCIOUSNESS NOT ASSOCIATED WITH A HEAD INJURY? _____

HOW OFTEN DOES YOUR CHILD HAVE ABSDOMINAL PAINS/VOMITING? _____
HOW OFTEN DOES YOUR CHILD HAVE HEADACHES? _____
HOW ARE HEADACHES TREATED? _____

DOES YOUR CHILD HAVE ANY DIFFICULTIES RELATED TO EATING? IF YES, PLEASE EXPLAIN.

_____

DOES YOUR CHILD HAVE ANY DIFFICULTIES RELATED TO SLEEPING? IF YES, PLEASE EXPLAIN.

_____

_____

HAS YOUR CHILD RECENTLY HAD HIS/HER HEARING CHECKED? IF YES, WHEN?

_____

HAS YOUR CHILD RECENTLY HAD HIS/HER VISION CHECKED? IF YES, WHEN?

_____

DOE YOUR CHILD HAVE HEARING OR VISION PROBLEMS?

_____

DOES YOUR CHILD HAVE A HISTORY OF FREQUENT EAR INFECTIONS? IF YES, HOW OFTEN?

_____

LIST ALL MEDICATONS YOUR CHILD CURRENTLY TAKES:

_____

_____

_____

DEVELOPMENTAL HISTORY

WHEN DID YOU OR ANYONE ELSE FIRST BECOME CONCERNED ABOUT YOUR CHILD'S DEVELOPMENT?

_____

_____

_____

MOTOR

AT WHAT AGE DID YOUR CHILD CRAWL? _____ WALK WITHOUT HOLDING ON _____
WAS YOUR CHILD SLOW TO DEVELOP MOTOR SKILLS OR AWKWARD COMPARED TO SIBLINGS AND/OR FRIENDS (E.G., RUNNING, BIKE RIDING, THROWING OR CATCHING A BALL)

_____

_____

WHEN DID YOUR CHILD DEVELOP A CLEAR HAND PREFERENCE? _____
IS YOUR CHILD ___ RIGHT HANDED ___LEFT HANDED ___ MIXED DOMINANCE

DOES YOUR CHILD HAVE ANY TROUBLE WITH HANDWRITING?

_____
_____

LANGUAGE

PLEASE FILL IN YOUR CHILD'S AGE WHEN S/HE:
SPOKE FIRST WORDS _____
SPOKE 2-3 WORDS TOGETHER _____

HAS YOUR CHILD HAD ANY SPEECH PROBLEMS (STUTTERING, DIFFICULT TO UNDERSTAND)?

_____

HAS YOUR CHILD EVER REQUIRED SPEECH THERAPY? IF YES, WHEN?

_____

DOES YOUR CHILD APPEAR TO HAVE PROBLEMS UNDERSTANDING AND PROCESSING ORAL LANGUAGE (E.G., FOLLOWING ORAL DIRECTIONS, UNDERSTANDING CLASSROOM PRESENTATIONS)?

_____
_____

DOES YOUR CHILD APPEAR TO HAVE PROBLEMS EXPRESSING HIM/HERSELF (E.G., TELLING A STORY, EXPLAINING A RECENT EVENT)?

_____
_____

DID YOUR CHILD EXPERIENCE DIFFICULTY SUCKING AS AN INFANT OR DIFFICULTY CHEWING AS A TODDLER?

_____

WAS YOUR CHILD SLOW IN LEARNING TO:

NAME COLORS?	___ YES ___ NO
RECITE THE ALPHABET?	___ YES ___ NO
COUNT TO TEN?	___ YES ___ NO

TOILET TRAINING

AGE YOUR CHILD WAS TRAINED FOR: URINE _____ BOWELS _____
DOES/DID YOUR CHILD HAVE BEDWETTING? ___ YES ___NO
IF YES: AGE STARTED_____ HOW OFTEN _____ AGE CONTROLLED _____
DOES/DID YOUR CHILD HAVE SOILING? ___YES ___ NO
IF YES: HOW OFTEN _____ TIME OF DAY _____

SOCIAL

AS AN INFANT OR TODDLER, DID YOUR CHILD SEEM TO ENGAGE WELL WITH OTHERS?

_____

_____

IN PRESCHOOL, DID YOUR CHILD GET ALONG WELL WITH OTHERS?

_____

_____

DID YOUR CHILD ENGAGE IN PRETEND PLAY?

_____

_____

CURRENTLY, DOES YOUR CHILD GET ALONG WELL WITH OTHER CHILDREN?

_____

CURRENTLY, DOES YOUR CHILD GET ALONG WELL WITH SIBLINGS?

_____

DOES YOUR CHILD HAVE FRIENDS? CAN YOUR CHILD KEEP FRIENDS?

_____

DOES YOUR CHILD HAVE TROUBLE READING SOCIAL CUES?

_____

DOES YOUR CHILD GET ALONG WELL WITH ADULTS?

_____

ATTENTION

DOES YOUR CHILD HAVE DIFFICULTY STAYING AT ONE ACTIVITY FOR A REASONABLE LENGTH OF TIME?

_____

DOES YOUR CHILD HAVE DIFFICULTY STAYING FOCUSED WHILE COMPLETING HOMEWORK?

_____

ARE THERE HOMEWORK BATTLES IN YOUR HOME?

_____

FAMILY HISTORY

PLEASE LIST YOUR CHILD'S FAMILY MEMBERS

RELATION	NAME	AGE	EDUCATION	OCCUPATION	HEALTH, SCHOOL, OR BEHAVIOR PROBLEMS
Parent					
Parent					
Sibling					
Sibling					
Sibling					

LANGUAGE SPOKEN AT HOME (IF NOT ENGLISH): _____

DOES ANYONE IN THE FAMILY (INCLUDING GRANDPARENTS, AUNTS, UNCLES, FIRST COUSINS) HAVE:

NEUROLOGICAL DISEASE ____YES ___ NO

ATTENTIONAL ISSUES ____YES ___ NO

PROBLEMS WITH DRUGS OR ALCOHOL ____YES ___ NO

LEARNING PROBLEMS ____YES ___ NO

Reading _____

Math _____

Written Language _____

LANGUAGE PROBLEMS ____YES ___ NO

Receptive _____

Expressive _____

TICS ____YES ___ NO

MOOD DYSREGULATON ____YES ___ NO

Depression _____

Bipolar _____

ANXIETY ____YES ___ NO

OCD _____

Generalized _____

PTSD _____

Phobia _____

THOUGHT DISORDER ____YES ___ NO

Schizophrenia ____YES ___ NO

ANY ADDITIONAL INFORMATION THAT YOU THINK WOULD BE IMPORTANT TO SHARE?