D E B R A K . S O W A L D , P S Y . D .
P S Y C H O L O G I S T
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(9 3 7) 4 3 4 – 6 8 4 0

Individual, Family, and Group Therapy
Psychological Assessment
Imagery & Senoi Dreamwork

FAMILY QUESTIONNAIRE

1. GENERAL INFORMATION

Child's Name:_____Date:_____
Age:_____Date of Birth:_____Sex:_____Home Phone:_____
Mother's Name:_____If not natural mother, give relation-
Ship:_____Work Phone:_____
Father's Name:_____ If not natural father, give relation-
Ship:_____Work Phone:_____
If not presently with the child, please give name and whereabouts of
biological parent(s):_____
Legal Custodian of child, if other than natural parent(s): _____
Is child adopted?_____ If yes, what age was child when adopted?_____
Please list all children, including those by previous and subsequent
marriages, and any deceased children with date of death:

Name	Birthdate	Grade or Occupation	Living in Household?

Name of person(s) completing this form:_____
Name of family physician: _____
Address: _____

CHILD'S CURRENT PROBLEMS AND THEIR HISTORY

1. Describe the child's current problem(s) (medical, behavioral, emotional):
_____
_____
_____
_____
_____
_____
_____
_____
_____
2. When did the current problems start or when were they first noticed?
_____
3. Is the child aware of the problem(s)?_____If yes, how is this awareness expressed:_____
4. Has the possibility of evaluation been discussed with the child?_____ If yes, what was the child's reaction?_____
5. List all professionals and agencies which have been involved in the current problem(s), dates of contact, and whether it was beneficial:
_____Date:_____beneficial?_____
_____Date:_____beneficial?_____
_____Date:_____beneficial?_____
6. Has the child had medical, behavioral, or emotional problems other than the current one(s)? ___no___yes. If yes, please specify and list agencies involved and dates of contact.
_____Date:_____beneficial?_____
_____Date:_____beneficial?_____

CHILD'S EDUCATION

1. School your child is presently attending:_____
Address:_____
Phone:_____Grade:___Principal:_____
Teachers:_____
2. How does your child do in school, in terms of grades, ability, and behavior?_____
_____
3. Has your child repeated any grades?____If yes, provide what grade and the reason for repeating the grade:_____

4. Has your child required special help in any of the schools attended? ____
Dates_____School_____Nature of help:_____Beneficial?_____
Dates_____School_____Nature of help:_____Beneficial?_____
5. Child's behavior problems in school:_____
_____

IV. CHILD'S DEVELOPMENT

A. Please list any problems encountered during the pregnancy and/or delivery and the first weeks of life:_____
_____
B. Was the child administered oxygen at birth? _____
Early development:
1. Was your child an easy-to-care-for infant?_____If not, please explain:
_____
2. Was your child an easy-to-care-for toddler?_____If not, please explain:_____
3. Please list any problems encountered in the first three years of life:_____
_____
4. If your child has started puberty, has the onset appeared to cause any difficulties?_____If yes, please give details_____
5. Has your child ever behaved or talked in a way that was not sexually appropriate for a boy/girl or his/her age?_____If yes, give details:
_____

Does the child exhibit any of the following: (Write a star on the left of those which are of special concern to you.)

	Yes	No
1. fears	___	___
2. much fantasy	___	___
3. much daydreaming	___	___
4. hallucinations (Seeing, hearing, smelling, tasting, feeling things which do not exist)	___	___
5. disorientation (confused regarding who he/she is, date, time, or place)	___	___
6. self-destructive behavior	___	___
7. suicidal thoughts or attempts	___	___
8. nervous habits or tics (e.g., nailbiting) state which:_____	___	___

	Yes	No
9. fitful sleeping	___	___
10. nightmares	___	___
11. sleep walking	___	___
12. poor attention or concentration	___	___
13. difficulty following instructions	___	___
14. difficulty solving problems	___	___
15. poor memory	___	___
16. poor coordination	___	___
17. poor speech articulation	___	___
18. stuttering	___	___
19. compulsive speech (can't seem to stop talking)	___	___
20. loss of memory	___	___
21. repeating words or sentences	___	___
22. repeating (echoing) what others say	___	___
23. no speech	___	___
24. difficulty distinguishing left from right	___	___
25. eating non-food material (Pica)	___	___
26. vandalism	___	___
27. fire setting	___	___
28. verbal aggression	___	___
29. physical aggression	___	___
30. cruelty to animals	___	___
31. lying	___	___
32. drug use, alcohol usage	___	___
33. smoking	___	___
34. stealing	___	___
35. bed-wetting	___	___
36. soiling	___	___
37. running away	___	___
38. sexual activity	___	___
39. poor appetite	___	___
40. headaches	___	___
41. hyperactivity	___	___
42. repetitive worries (obsessions)	___	___
43. repetitive behaviors (compulsions)	___	___
44. disorganized	___	___
45. other: describe_____		

CHILD'S HEALTH

1. Does your child have any allergies? ____If yes, please give details:
_____
2. Has your child ever had fever above 105 degrees?_____If yes, please Give child's age at the time and the cause:_____
3. Has this child had any significant accidents or injuries (including broken Bones)?_____If yes, give details_____
4. Has your child ever lost consciousness?____If yes, give details:_____
_____
5. Has your child ever been hospitalized?_____If yes, give details_____
_____
6. Has your child had any operations?_____If yes, give details_____
_____
7. Has your child ever had seizures (convulsions)_____If yes, give details:
_____
8. Has your child ever received medications in the past for emotional, physical, learning, or behavioral problems?_____If yes, please give the following details:
Problem: _____
Age when first prescribed: _____
Medication:_____Daily Dose:_____
Times per day:_____Taken since: (date)_____
Who prescribed the medication(s)?_____
Is it helping?_____Side effects? _____

9. Is the child presently taking any other medications?____If yes:
Problem: _____
Age when first prescribed _____
Medication:_____Daily Dose:_____
Times per day:_____Taken since: (date)_____
Who prescribed the medication(s)? _____
Is it helping?_____Side effects? _____

10. Please describe any occurrences of birth defects, mental retardation, nerve disease (cerebral palsy, epilepsy) and psychiatric condition in the immediate family and the child's blood relatives:
_____
_____

VI. SIGNIFICANT EVENTS

1. Have any of the following events occurred in your family? If so, please Describe:

Event	Year	Describe
___move to a new place	____	_____
___significant separation from a parent	____	_____

Event	Year	Describe
___loss of someone very close	___	_____
___frightening experiences	___	_____
___change of school	___	_____
___serious illness or injury in family	___	_____
___death in family	___	_____
___change in family's financial status	___	_____
___promotion	___	_____
___loss of job	___	_____
___change of job	___	_____
___separation or divorce	___	_____
___brother or sister leaving home	___	_____
___marriage of sibling	___	_____
___emotional difficulties	___	_____
___legal problems	___	_____
___other (specify)	___	_____

VII. FAMILY

1. List relatives or others living in the household.

Name	Age	Relationship	Grade or Occupation

2. Marital History

   A. How would you describe your marital relationship? _____
   _____

   B. Have you sought outside help with regards to marital problems? ____
   If yes, please give details. _____
   _____

3. Have any family members had problems with substance abuse (drugs, alcohol)?____If yes, please give details_____
4. Have any family members been involved in incest (sexual interaction between a parent and child or between the children)?_____If yes, please give details: _____
_____

5. Has any family member been sexually, physically, or emotionally abused? _____If yes, please give details:_____
_____
_____

6. Please describe any problems that occurred while the child's father was growing up:_____
_____

7. Please describe any problems that occurred while the child's mother was growing up: _____
_____

8. Please describe any problems that occurred while the child's adoptive, step, or foster parent(s) or guardians were growing up:_____
_____
_____