Pediatric Professional Association
Psychology
Family Information Form
Ages 1-12 years

General Background

Child's name ____________________________________ Nickname __________________
Age _____________Birthdate___________________Gender______________________
Address ____ Home Phone _____________
City, State ____ Zip Code ________________
Father's Name __________________________ Age ______ Work/Cell Phone __________
Mother's Name__________________________ Age______ Work/Cell Phone __________

Relationship to Child: (Circle 1)
Marital Status: Unmarried _______
Father: Natural Adoptive Foster Step Married __________ Divorced __________
Mother: Natural Adoptive Foster Step Married __________ Divorced __________

Other Children: Name Age Gender

____
____
____
____

Who referred you? _________________ Name of Child's Doctor ______________________
Reason for Referral:____
____

Parent Information

Education – Highest Grade Completed Mother______ Father_______
Employment- Job Position:
Father____ Hours a week: _______________
Mother____ Hours a week: _______________
Describe any additional job circumstances that may be important_______________________
____
____

Do you think the family is under a financial strain? Yes _____ No_____

Describe a typical weekday and weekend for parents and child

____
____
____
____
____
____
____

Has either parent ever received counseling or psychotherapy? ______Yes _____No

If yes, describe problem, therapist, any medication, current status and dates:

____
____
____
____
____

How would you describe your marriage during the past six months? (circle one)
Very Good Good Fair Bad Very Bad

How would you describe your marriage during the last month? (circle one)
Very Good Good Fair Bad Very Bad

Do you and your spouse agree on the 2 previous questions? _____ Yes ______No
If not how would your spouse rate these questions? ___________________________________

Siblings not applicable ____

Please list names, gender, and ages of siblings

____
____
____

Have any of your other children ever received counseling or psychotherapy? ___Yes ___No

If yes, describe problem, therapist, any medication, current status and dates:

____
____
____
____
____

Do any of your other children have an emotional or behavioral problem that concerns you?

____
____
____

Do any of your other children have physical health problems that interfere with normal functioning?

____
____
____

Child Growth and Development

Birth Weight ___________________ Normal Pregnancy ____Yes ____No
Normal labor and delivery ____Yes ____No General infant development: Poor Fair Good
Note the month your child achieved the following activites:
Sat alone_____ Crawled_____ Walked _____ Fed Self _____ Spoke words _____

Current weight ___________ Current height ______________
Does this child have a physical health problem that interferes with typical functioning?

____
____
____

Is your child on any medication at the present time? ____Yes ____No
What kind and who prescribed? _____________________________ Why?_______________
How long has he/she been on the medication _______________________________________
Does it affect his/her behavior? ______ How?_______________________________________

Has your child ever received counseling or psychotherapy? ____Yes ____No
If yes, describe problem, therapist, any medication, current status and dates:

____
____
____
____
____

How are your child's relationships with the following: (circle one for each)

Father:	Very Good	Good	Fair	Bad	Very Bad
Mother:	Very Good	Good	Fair	Bad	Very Bad
Siblings:	Very Good	Good	Fair	Bad	Very Bad

____
____
____

Bedtime

What time do you usually begin getting your child read for bed? ________________________
What time is s/he usually in bed?____
What time is s/he usually asleep?____
How many times does s/he usually wake up?_______________________________________
Do you go to her/him when s/he awakens?____
Where does s/he fall asleep?____
Where does s/he wake up?____
Who puts her/him to bed?____

Meals

What are your child's favorite foods?

____

____

What are some foods that s/he doesn't like? ____________________________________

How long does a meal typically last?____________________________________

How many times does s/he typically disrupt the meal?______________________

What kind of snacks does s/he prefer?____________________________________

How often does s/he get snacks? ____________________________________

Discipline

Who ordinarily disciplines your child? ____________________________________

How is your child disciplined? Yell____ Spank____ Reasoning____ Time out ____

Take away privileges _____ Send to room ____

How often do you need to use discipline? ____________________________________

Have your methods of discipline been effective? ______________________________

Do parents agree on discipline?____________________________________

School

What school, if any, does your child attend? ______________________________

Address

____

Teacher's name ________________________Principal's name ______________________

Grade _________ progress: (circle one) Poor Fair Good Very Good

Phone: __________________________ Hours in Attendance: ______________________

Have you had extra conferences with teacher or school authorities for behavior or learning problems? ____

What do they suggest is needed to help your child? ______________________________

Do you agree with teacher, or what are your ideas about what is needed?

____

____

Which of the following have been or are now problems with your child?

	Yes	No	Sometimes		Yes	No	Sometimes
Won't Mind	___	___	___	Head banging	___	___	___
Too Active	___	___	___	Soiling	___	___	___
Bad Temper	___	___	___	Bedwetting	___	___	___
High Strung or				Cries a lot	___	___	___
Nervous	___	___	___	Clings to parents	___	___	___
Breath holding	___	___	___	Toilet Training	___	___	___
Easily upset	___	___	___	Too shy	___	___	___
Clumsy	___	___	___	Brother/Sisters	___	___	___
Nightmares	___	___	___	Thumb sucking	___	___	___
Destructive	___	___	___	Pacifier	___	___	___
Hyperactive	___	___	___	Startles easily	___	___	___