

Pediatric Professional Association
Psychology
Family Information Form
Infant (<1year)

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 activities:
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 _____

Put in crib _____ for how long? _____ Take away privileges _____

How often do you need to use discipline? _____

Have your methods of discipline been effective? _____

Do parents agree on discipline? _____

Childcare

What childcare facility, if any, does your child attend? _____

Address

Provider's name _____ Director's name _____

Phone: _____ Hours in Attendance: _____

Have you had extra conferences with teacher or daycare authorities for behavior or learning problems? _____

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

Do you agree with care providers, 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 Nervous	___	___	___	Cries a lot	___	___	___
Breath holding	___	___	___	Clings to parents	___	___	___
Easily upset	___	___	___	Toilet Training	___	___	___
Clumsy	___	___	___	Too shy	___	___	___
Nightmares	___	___	___	Brother/Sisters	___	___	___
Destructive	___	___	___	Thumb sucking	___	___	___
Hyperactive	___	___	___	Pacifier	___	___	___
				Startles easily	___	___	___