Spectrum Psychological Associates, Inc.
Background Information - Child

Child's First Name: _____ Middle Initial: ___ Last Name: _____

Age: _____ Birth Date: ____/____/_____ SSN: _____

Mother's Name: _____

Father's Name: _____

With whom does the child live**? Please circle one**: Mother, Father, Both Parents, Shared Custody Between Mother & Father or Other. If other, please describe: _____

Are the parents separated? **Please circle one**: Yes or No. If yes, when were the parents separated? _____

Are the parents divorced? **Please circle one**: Yes or No. If yes, when were the parents divorced? _____

Are there additional siblings besides those listed on page 2 of the Background Information form**? Please circle one**: Yes or No. If yes, please list them below (including half siblings, step siblings).

Name	Age	Gender (circle one)
_____	_____	M / F
_____	_____	M / F
_____	_____	M / F

What concerns do you have about your child? _____

_____

_____

What grade is your child in? _____

What school does your child attend? _____

In general, what is your child's attitude towards school? **Please circle one**: Very negative, Negative, Neutral, Positive or Very positive.

Overall, please indicate the level of your child's grades/academic performance. **Please circle one**: Nearly failing, Below average, Average, Above average or Superior.

About how many hours of sleep does your child get each night? _____

Developmental History

Length of pregnancy: _____ weeks

What was the mother's age when the child was born? _____

What was the child's birth weight? _____

Please describe any problems that affected your child during delivery or during the first few months after birth:

_____

_____

_____

Please turn to the next page

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At what age did your child first accomplish the following?
Age
____ Sitting without help
____ Crawling
____ Walking alone, without assistance
____ Using single words (Mama, Dada)
____ Putting two or more words together
____ Bowel training, day and night
____ Bladder training, day and night

Please describe any difficulties with toilet training that your child has experienced: _____

_____

_____

_____

Medical Experience
Does your child have any medical problems? **Please circle one**: Yes or No. If yes, please describe: _____

_____

_____

_____

_____

Please list any medications that your child is currently taking: _____

_____

_____

_____

_____

_____

Does your child have any developmental, behavioral or learning problems? **Please circle one**: Yes or No. If yes, please describe: _____

_____

_____

_____

_____

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