Baker Neuropsychology
and Learning Center

Comprehensive Background Questionnaire

Child's name: _____ Date of birth: ____/____/_____

Child's age: _____

Name of person completing form: _____

Relationship to child:_____ Date form completed:____/___/____

Who referred you for this evaluation?_____

PURPOSE OF EVALUATION

Describe the main concerns for which you are seeking this evaluation:

1.

2.

3.

Has your child ever received an evaluation or treatment for these concerns? If yes, when and by whom?

What are you hoping to learn or gain from this evaluation?

FAMILY & HOME INFORMATION

Please list the persons who are currently living in the home with the child:

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any family members who are no longer at home:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Caregiver 1 name: _____ Age: _____

Relationship to child:_____ Highest level of education completed: _____

Occupation: _____Place of employment: _____

Caregiver 2 name: _____ Age: _____

Relationship to child:_____ Highest level of education completed: _____

Occupation: _____Place of employment: _____

Other caregiver's name (if applicable): _____ Age: _____

Relationship to child:_____ Highest level of education completed: _____

Occupation: _____Place of employment: _____

Parents are currently:

Married _____ Separated _____ Divorced _____ Unmarried _____ Widowed _____

If parents are divorced, who has legal custody? _____

If parents are separated or divorced, please describe visitation arrangements: _____

_____

_____

Is this child? Biological _____ Adoptive _____ Foster _____

Are any languages other than English spoken in the home? No Yes If yes, which? _____

What language does your child prefer for communication? _____

Please describe any family stresses your child has experienced in the last several years (e.g., death, serious illness, unemployment, marital problems, moves, etc.): _____

_____

_____

_____

Please list anyone in the immediate or extended biological family with language, learning or attention problems:

Family member (parent, brother, sister, grandparent, uncle, etc.)	**Type of problem** (learning disability, ADHD dyslexia, math challenges, language disorder, etc.)

Please list anyone in the immediate or extended biological family with mental illness challenges:

Family member (parent, brother, sister, grandparent, uncle, etc.)	**Type of problem** (depression, anxiety, bipolar, schizophrenia, law troubles, drug abuse, etc.)

Familial-genetic medical history:

Family member	**Describe problem(s)**

BIRTH INFORMATION

Was there regular medical care during this pregnancy? Yes No

Were there any problems during the pregnancy? Yes No
If yes, please describe the problem and when it occurred during the pregnancy (such as diabetes, excess vomiting, bleeding, high blood pressure, toxemia, weight loss, fever, accidents): _____
_____
_____

Were alcoholic beverages or illicit drugs consumed during this pregnancy? Yes No
If yes, what substances and how frequent?
_____

Were prescription medications taken during this pregnancy? Yes No
If yes, please list: 1) _____
2) _____
3) _____

Was this baby carried a full term (38-40 weeks)? Yes No
If no, please indicate length of pregnancy in weeks: _____

Describe type of labor (e.g., fast, long, easy, hard)? _____
How long did labor last in hours? _____

Were there any problems with the delivery? Yes No
If yes, please describe the problems (emergency Cesarean section, slow heart rate, fever, cord around neck, etc.): _____
_____
_____

Apgar scores at birth (if known)? _____

How much did the baby weigh at birth? _____ Pounds _____ Ounces

How many days did the baby remain in the hospital? _____

Did the newborn require any special care shortly after birth? Yes No
If yes, please describe the type of care (oxygen, incubator, blood transfusions, medications, etc.): _____
_____
_____

DEVELOPMENTAL INFORMATION

At approximately what age did your child:

Say single words meaningfully? _____ Walk without help? _____

Combine 2 or more words? _____

Which hand does your child prefer for writing/drawing? _____ eating? _____ sports? _____

Compared to other children, do you feel your child has had any problems with:

YES	NO	ITEM DESCRIPTION	EXPLANATION
		Learning to talk?	
		Understanding language?	
		Unclear speech/poor articulation?	
		Building with blocks, playing with puzzles, drawing, etc.?	
		Gross motor skills (walking, hopping, riding bike, etc.)?	
		Fine motor skills (fastening buttons, zippers, drawing, etc.)?	
		Toilet-training?	
		Bed-wetting?	
		Excessive daytime sleepiness?	
		Snoring?	
		Excessive restlessness while sleeping?	
		Nightmares?	
		Sleep walking?	
		Separating from parents?	
		Unusual fears?	
		Early school-related skills (naming colors, counting, alphabet)?	
		Playing or socializing with other children?	
		Unusual interests, habits, or routines?	
		Sitting still?	
		Paying attention or concentrating?	
		Managing frustration?	
		Aggression?	
		Other difficulties not listed above?	

MEDICAL INFORMATION

Has your child ever been hospitalized? Yes No
If yes, please list ages and reasons: _____

_____

_____

Has your child ever had surgery? Yes No
If yes, please list ages and reasons: _____

_____

Has your child ever sustained a concussion or more severe brain injury? Yes No
If yes, what happened and when? _____

_____

Has your child ever had a seizure or convulsion? Yes No
If yes, please describe, including ages and medications that were prescribed, if any: _____

_____

Does your child have any allergies? Yes No
If yes, please describe: _____

Does your child have frequent abdominal pains or vomiting? Yes No
If yes, when does this occur? _____

Does your child have frequent or severe headaches? Yes No
If yes, how are they treated? _____

Does your child have any vision problems? Yes No
Please specify: _____

Does your child have any hearing problems? Yes No
Please specify: _____

Does your child have a history of frequent ear infections? Yes No
If yes, please describe how often and at what ages: _____

Does your child have sleep difficulties? Yes No
If yes, please describe the sleep concerns: _____

_____

Is your child currently taking any medications? Yes No

If yes, please list:	Reason child is taking:
_____	_____
_____	_____
_____	_____

Primary Medical Provider/Pediatrician:

Provider Name: _____

Phone Number: _____

SCHOOL INFORMATION

Current school name: _____

Current grade: _____

Phone number: _____

Who is the best contact person for details of your child's schoolwork? _____
(*I will not contact this person without your permission*.)

Has your child ever repeated a grade? Yes No
If yes, which grade(s)? _____

Has your child ever had a 504 Plan or Individualized Education Plan (IEP)? Yes No
If yes, why? _____

If yes, is the plan ongoing? _____

If yes, which grade was this started? _____

If yes, when was s/he last evaluated? _____

Over the years, how have teachers generally described your child? _____

_____

Does your child have any relative strengths/weaknesses at school? (e.g., better in reading than math, bright but trouble focusing or disorganized): _____

What is the typical range of grades your child receives on his/her report card (e.g., A to C; B to D; satisfactory)? _____

If applicable, what is your child's cumulative grade point average (GPA)? _____

Describe what type of support your child typically needs to complete homework: _____

_____

Please circle the statement that best describes your child's motivation to succeed in school:
A. More motivated to achieve success than most children
B. About as motivated to achieve success as most children
C. Less motivated to achieve success than most children

Has your child ever qualified for gifted/talented services? Yes No

Has your child ever received any of the following services?

	Yes	***No***	***Ages / Grades***	***Through school system, private, both?***
Speech/language therapy	____	____	_____	_____
Physical therapy	____	____	_____	_____
Occupational therapy	____	____	_____	_____
Academic tutoring	____	____	_____	_____
School counseling	____	____	_____	_____

OTHER INFORMATION

Has your child been given any learning, psychological, or other diagnoses? Yes No
If yes, please specify: _____

Has your child ever been evaluated or treated by a psychologist, psychiatrist, or counselor? Yes No
If yes, describe reasons, when, and by whom: _____

Does your child have any serious emotional/mood problems? Yes No
(e.g., depression, anxiety) If yes, please explain: _____

Does your child have any serious behavioral problems? Yes No
If yes, please explain: _____

Has your child ever been suspended or expelled from school? Yes No
If yes, please explain why: _____

Has your child ever been arrested or involved with the police or legal/court system for any reason? Yes No
If yes, please explain why: _____

Describe how your child typically gets along with his or her peers: _____

Does your child prefer to play with older, younger, or same-age children? _____

What activities does your child enjoy when not in school? _____

What do you consider your child's best qualities or strengths? _____

What do you consider your child's weaknesses? _____

Primary Parents/Caregivers: _____

Street Address: _____

City, State, & Zip Code: _____

Preferred Telephone #: _____