Cornerstone Assessment and Guidance Center, LP
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Background Questionnaire:

Demographic Data:

Child's Name: _____ Today's Date:_____
Child's date of birth: _____ Age: _____ Gender: ☐ Male ☐ Female
Home Address:
_____
_____
_____

School: _____ Teacher: _____
Grade (in the summer most recently completed grade):_____

Person filling out this form: ☐ mother ☐ father ☐ stepmother
☐ stepfather ☐ other:_____

Mother's Name: _____ Age: _____ Education: _____
Occupation: _____
Phone: Home:_____ Work:_____
Cell: _____ E-Mail:_____

Father's Name: _____ Age: _____ Education: _____
Occupation: _____
Phone: Home:_____ Work:_____
Cell: _____ E-Mail:_____

Stepmother's Name: _____ Age: _____ Education: _____
Occupation: _____
Phone: Home:_____ Work:_____
Cell: _____ E-Mail:_____

Stepfather's Name: _____ Age: _____ Education: _____
Occupation: _____
Phone: Home:_____ Work:_____
Cell: _____ E-Mail:_____

Marital status of parents: _____
If separated or divorced, how old was the child when the separation occurred? _____
If remarried, how old was the child when the stepparent entered the family? _____

List all people living in the household:

Name	Relationship to Child	Age

List all brothers, sisters or other significant people living outside the household:

Name	Relationship to Child	Age

Recent family stressors (deaths, births, moves, job loss, etc.):

Dominant language spoken in the home: _____
Other languages spoken in the home: _____

Was your child adopted? ☐ Yes ☐ No
If yes, at what age? _____
Does the child know? ☐ Yes ☐ No

Name of pediatrician: _____
Name of other significant health care providers: _____

Who referred you to Cornerstone Assessment?_____

Presenting Problem:

Briefly describe your child's current difficulties:

How long has this problem been of concern to you?

When was this problem first noticed?

What seems to help the problem?

What seems to make the problem worse?

In your opinion, what is the major cause of your child's difficulties ("I don't know" is a perfectly reasonable answer)?

Do both parents agree about the nature and cause of the problem?

Have you noticed changes in your child's abilities? ☐ Yes ☐ No
If yes, please describe:

Have you noticed changes in your child's behavior? ☐ Yes ☐ No
If yes, please describe:

Has your child received evaluation or treatment for the current problem or similar problems? ☐ Yes ☐ No
If yes, when and with whom?

Is your child being treated for a medical illness?☐ Yes ☐ No
If yes, for what condition is the child being treated?

Is your child on any medications at this time? ☐ Yes ☐ No
If yes, please fill out the chart below:

Medication:	Dosage:	Reason for medicine:

Social and Behavioral Checklist:

Place a check next to any behavior or problem that your child *currently* exhibits:

☐ Has difficulty with hearing
☐ Has difficulty with vision
☐ Has difficulty with coordination
☐ Has difficulty with balance
☐ Has difficulty making friends

☐ Has difficulty keeping friends
☐ Refuses to share
☐ Prefers to be alone
☐ Does not get along well with brothers/sisters
☐ Fights verbally with adults
☐ Yells and calls children names
☐ Shows wide mood swings
☐ Is aggressive (describe) _____
☐ Is withdrawn (describe) _____
☐ Is shy or timid
☐ Clings to others
☐ Tires easily, has little energy
☐ Is more interested in things (objects) than people
☐ Engages in behavior that could be dangerous to self or others (describe) _____
☐ Breaks objects deliberately
☐ Lies (describe) _____
☐ Steals (describe) _____
☐ Injures self often accidentally
☐ Injures self on purpose
☐ Runs away
☐ Has low self-esteem
☐ Blames others for his or her troubles
☐ Is argumentative
☐ Does not get alone well with other children
☐ Fights verbally with other children
☐ Fights physically with other children
☐ Does not show feelings
☐ Has frequent crying spells
☐ Has unusual or special fears, habits, or mannerisms (describe) _____
☐ Wets bed
☐ Sleepwalks
☐ Sucks thumb
☐ Bites nails
☐ Has frequent temper tantrums
☐ Has trouble sleeping (describe) _____
☐ Rocks back and forth
☐ Bangs head
☐ Snores while sleeping
☐ Eats poorly
☐ Is stubborn
☐ Has poor bowel control (soils self)
☐ Is much too active
☐ Is fidgety
☐ Is easily distracted
☐ Is disorganized
☐ Is clumsy
☐ Is unusually talkative

☐ Is forgetful
☐ Has blank spells
☐ Daydreams too much
☐ Worries a lot
☐ Is impulsive
☐ Takes unnecessary risks
☐ Gets hurt frequently
☐ Has too many accidents
☐ Doesn't learn form experience
☐ Feels that he or she is bad
☐ Is slow to learn
☐ Moves slowly
☐ Stares into space for long periods
☐ Engages in repetitive behavior (e.g. Hand flapping, wheel spinning) _____
☐ Does not understand other people's feelings
☐ Has difficulty following directions
☐ Gives up easily
☐ Complains of aches or pains
☐ Is disobedient
☐ Has tics or twitches
☐ Constantly seeks attention
☐ Has periods of confusion or disorientation
☐ Is restless
☐ Is jealous (describe) _____
☐ Is extremely selfish
☐ Feels hopeless
☐ Is nervous or anxious
☐ Is immature
☐ Is easily frustrated
☐ Has difficulty learning when there are distractors
☐ Is suspicious of other people
☐ Requires constant supervision
☐ Has difficulty resisting peer pressure
☐ Shows anger easily
☐ Has difficulty accepting criticism
☐ Feels sad or unhappy often
☐ Talks about wanting to die
☐ Has poor attention span
☐ Has poor memory
☐ Sets fires
☐ Is afraid of new situations
☐ Has trouble making plans
☐ Eats inedible objects
☐ Is not toilet trained
☐ Uses illegal drugs (describe) _____
☐ Drinks alcohol
☐ Shows sexually provocative behavior

☐ Has extreme fear of bathroom or bathing
☐ Has anxiety when separated from parents
☐ Has extreme anxiety about going to school
☐ Has fear of bedtime
☐ Is wary of any physical contacts with adults in general
☐ Refuses to sleep alone
☐ Refuses to go to bed
☐ Has loss of bladder control
☐ Is fearful of strangers
☐ (in cases of divorce) Is fearful of visiting a parent or caregiver
☐ Overeats
☐ Is very eager to please others
☐ Has compulsion about cleanliness – wanting to wash or feeling dirty all the time
☐ Other Problems (describe) _____

Language and Speech Checklist:

☐ Speaks in shorter sentences than expected for age
☐ Does not know names of common objects
☐ Has difficulty recalling familiar words
☐ Substitutes vague words (e.g. “thing”) for specific words
☐ Responds better to gestures than to words
☐ Does not make appropriate gestures to communicate
☐ Uses gestures instead of words to express ideas
☐ Has difficulty making speech understood
☐ Speaks very slowly
☐ Speaks too fast
☐ Is often hoarse
☐ Has unusually loud speech
☐ Has unusually soft speech
☐ Makes sound but no words
☐ Mixes up the order of events
☐ Seems uninterested in communicating
☐ Prefers to speak to adults only
☐ Prefers to speak to children only
☐ Prefers to speak to family members only
☐ Speaks in a monotone, song song, or exaggerated manner

Educational Checklist:

☐ Has difficulty with reading
☐ Has difficulty with arithmetic

☐ Has difficulty with spelling
☐ Has difficulty with handwriting
☐ Has difficulty with other subjects (please list) _____
☐ Has difficulty paying attention in class
☐ Has difficulty sitting still in class
☐ Has difficulty waiting turn in school
☐ Has difficulty taking notes in class
☐ Has difficulty respecting others' rights
☐ Has difficulty remembering things
☐ Forgets homework
☐ Has difficulty getting along with teacher
☐ Has difficulty getting along with other children
☐ Dislikes school
☐ Resists going to school
☐ Refuses to do homework

Did your child attend preschool? ☐ Yes ☐ No
If yes, at what ages? _____ How often? _____
Name of Preschool(s)_____

At what age did your child begin kindergarten? _____
What is his or her current grade? _____
How are your child's grades or marks? _____

Is your child in any special education classes? ☐ Yes ☐ No
If yes, what type of class? _____

Has your child been held back in a grade? ☐ Yes ☐ No
If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? ☐ Yes ☐ No
If yes, please describe: _____

Has your child ever received special tutoring or therapy outside of school?☐ Yes ☐ No
If yes, please describe: _____

Has your child's school performance recently declined? ☐ Yes ☐ No
If yes, please describe: _____

Has your child missed a lot of school? ☐ Yes ☐ No
If yes, please indicate reasons: _____

Does you child attend day care after school? Where? How many hours a day?

Pregnancy and Birth History:

Were there any problems during the pregnancy with your child? ☐ Yes ☐ No
If yes, please describe

Was your child exposed to cigarette smoke in utero? ☐ Yes ☐ No
Details:

Was your child exposed to any other problematic substances in utero (e.g. medications, drugs, alcohol, X-rays, chemicals, etc)? ☐ Yes ☐ No
Details:

Was your child exposed to any infectious diseases in utero?☐ Yes ☐ No
Details:

Were there any issues of blood incompatibility?

How long was labor?

Was a c-section performed?

Was child delivered breach?

Were there any complications associated with the delivery? (e.g. Umbilical cord around neck, lack of oxygen, meconium staining, jaundice, etc.)

Was the child premature? ☐ Yes ☐ No
If yes, by how many weeks? _____

APGAR scores (if known):_____
Did your child have trouble breathing? _____

Was Neonatal care needed? ☐ Yes ☐ No
If yes, what kind of care and how long was it needed?

☐ NICU
☐ Special Care Nursery
☐ Other

What was your child's birth weight? _____

Was there anything else unusual about pregnancy or birth?

Infancy:

Were there any birth defects or complications? ☐ Yes ☐ No
If yes, please describe:

Were there any feeding problems? ☐ Yes ☐ No
If yes, please describe:

Were there any sleeping problems? ☐ Yes ☐ No
If yes, please describe:

Describe your child as an infant (quiet, alert, fussy, etc.)

Did your child like to be held as an infant? ☐ Yes ☐ No
Did your child grow normally? ☐ Yes ☐ No

First Years / Developmental History:

During your child's first years, did he or she show any of the following behaviors? Place a check next to each one that he or she showed:

☐ Did not enjoy cuddling
☐ Was not calmed by being held
☐ Was colicky
☐ Was excessively restless
☐ Had poor sleep patterns
☐ Banged head frequently (describe) _____
☐ Was constantly into everything
☐ Had an excessive number of accidents
☐ Was exposed to lead
☐ Had fine-motor problems
☐ Had gross-motor problems
☐ Did not babble
☐ Did not speak
☐ Had excessive fears
☐ Ignored toys
☐ Was attached to an unusual object (specify) _____
☐ Was unaware of painful bumps or falls
☐ Had peculiar pattern of speech
☐ Preferred to play alone
☐ Had poor eye contact

☐ Was not interested in other children
☐ Did not smile socially
☐ Was insensitive to cold or pain
☐ Did not wave bye-bye

Motor Development:

Age crawled alone____ Walked alone _____

Was your child slow to develop motor skills or awkward compared to siblings, friends (e.g. Running, skipping, climbing, biking, playing ball?)

_____
_____
_____

Handedness: Right____ Left____ Both_____
Family history of left handedness? (List relatives) _____
Was Physical Therapy ever necessary? (when?) _____
Was Occupational Therapy ever necessary? (when?) _____

Speech/Language Development:

Age spoke first word _____ put 2-3 words together _____

Speech delays/problems (e.g. Stutters, difficult to understand)?_____
Oral-motor problems (e.g. Late drooling, poor sucking, poor chewing)? _____
Was speech/language therapy ever necessary? _____
Was child slow to learn the alphabet? _____ name colors? _____ count? _____

Were their any other special problems in the growth and development of your child during the first few years? ☐ Yes ☐ No
If yes, Please describe:

_____

Medical History:

Place a check next to any illness of conditions that your child has had. When your check an item, also note the approximate age of the child when he or she had the illness or condition:

	Age
☐ Measles	_____
☐ Head Injuries	_____
☐ Mumps	_____
☐ Chicken pox	_____
☐ Whooping cough	_____
☐ Diphtheria	_____

☐ Polio _____
☐ Scarlet fever _____
☐ Meningitis _____
☐ Encephalitis _____
☐ High fever _____
☐ Convulsions _____
☐ Allergies _____
(please list)
☐ Injuries to head _____
☐ Seizures _____
☐ Broken bones _____
☐ Hearing problems _____
☐ Ear infections (tubes needed?) _____
☐ Sleeping problems _____
☐ Fainting spells _____
☐ Loss of consciousness _____
☐ Paralysis _____
☐ Dizziness _____
☐ Frequent headaches _____
☐ Difficulty concentrating _____
☐ Memory problems _____
☐ Extreme tiredness _____
☐ Rheumatic fever _____
☐ Epilepsy _____
☐ Tuberculosis _____
☐ Bone or joint disease _____
☐ Gonorrhea or syphilis _____
☐ Anemia _____
☐ Jaundice _____
☐ Hepatitis _____
☐ Diabetes _____
☐ Cancer _____
(list type)
☐ High blood pressure _____
☐ Heart disease _____
☐ Asthma _____
☐ Bleeding problems _____
☐ Eczema or hives _____
☐ Suicide attempts _____
☐ Sleeping problems _____
☐ HIV _____
☐ AIDS _____

Does your child have any disabilities?

Has your child had any serious illnesses?

Has your child been hospitalized?

Has your child had any operations?

Has your child had any accidents?

Are your child's immunizations up to date?

Child's height? _____
Child's weight? _____
Do you have concerns regarding your child's weight or eating habits?_____
_____
_____

Date of any vision evaluation:_____ Results: _____
Date of any hearing evaluation:_____ Results: _____

Family Medical History:

Place a check next to any illness or conditions that any member of the immediate family has had. When you check an item, please note the family member's relationship to the child.

	Relationship to child
☐ Academic problem or Learning Disability	_____
☐ Alcoholism	_____
☐ Cancer	_____
☐ Depression	_____
☐ Developmental problem or Mental Retardation	_____
☐ Diabetes	_____
☐ Drug problem	_____
☐ Emotional problem	_____
☐ Epilepsy	_____
☐ Autism/ Asperger's	_____
☐ Anxiety	_____
☐ Heart trouble	_____
☐ Neurological disease	_____
☐ Suicide attempt	_____
☐ Other problem (please list)	_____

Child's Activities:

What does your child like to do for fun?

List any after school activities that your child has in the table below:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does your child have any special areas of talent?

What is your child's favorite thing to do with free time?

What is your child's favorite TV program? Video game?

How many hours does your child spend watching TV per week (approx):_____
How many hours does your child spend playing video games per week (approx):_____

What do you hope to learn from the present evaluation?

What are three wonderful traits that you see in your child?

What is one less desirable trait that your child possesses?

Please indicate any daily routines that you and your child have (i.e. evening routine):

List two books that you have recently read to your child:

List two books that your child has recently read:

Does your child have any chores around the house? Please list:

Has your child ever been in trouble with the law?

How do you typically discipline your child?

Is this method of discipline effective?

What activities do you and your child enjoy together?

Does your child ask religious/spiritual questions? How have you handled these questions?

List three of your child's strengths

List your child's greatest weakness

Is there anything that you would like me to know about your child that is not covered above?

Thank you for taking the time to fill out this questionnaire. The process of an evaluation is much richer with the detail that you can provide. After all, you have likely come to know your child quite well! This information helps me to better understand your child as a complete person. With that knowledge, the test findings can be much more accurately interpreted.