



Child Biographical Questionnaire

Psychological Services

Child's Name _____ Gender: Male Female
 (first name, surname)

Date Visited _____ Date of Birth _____ Age _____
 DD/MM/YYYY

School _____ Grade _____

Language(s) used at home: _____
 If more than one, circle primary language

Form completed by _____
 (name, relation to child)

How did you hear about us?
 Friend Recommended Doctor
 School Other _____
 Website

1), General Information

	<i>Mother</i>	<i>Father</i>
Name	_____	_____
Telephone (Home)	_____	_____
(Work) or (Mobile)	_____	_____
Email Address	_____ @ _____	_____ @ _____
Please indicate primary contact person with an astrix (*) or list alternate person here _____		

Home Address: _____

Other people living at home - apart from parent(s) and child

<i>Name</i>	<i>Age</i>	<i>Relationship to child</i>	Tick to indicate main caregiver(s)
_____	_____	_____	<input type="checkbox"/> Parent(s)
_____	_____	_____	<input type="checkbox"/> Gandparents
_____	_____	_____	<input type="checkbox"/> Aunt / Uncle
_____	_____	_____	<input type="checkbox"/> Maid / Helper
_____	_____	_____	
_____	_____	_____	

2). Health History**Birth Details:**

Pregnancy length (weeks) _____ Weight at birth _____

Birth procedure (e.g. normal, breech, caesarean) _____

During pregnancy were there complications or problems? No YesDuring birth and immediately following, did complications occur for child or mother? No Yes*If yes, please describe (e.g. Diabetes, jaundice, breathing problems, need of incubation, swallowing difficulties)***Developmental Milestones***If known, at what age did the following occur:*

Crawl _____	Day time bladder trained _____
Walk (unassisted) _____	Night time bladder trained _____
First sounds _____	<i>Can your child.....</i>
First words _____	Tie shoelaces <input type="checkbox"/> No <input type="checkbox"/> Yes
Use 2 word sentence _____	Catch a ball <input type="checkbox"/> No <input type="checkbox"/> Yes
	Use scissors <input type="checkbox"/> No <input type="checkbox"/> Yes

Has your child been involved in a major accident/undergone surgery? (injuries requiring hospitalisation) No Yes

Details: _____

Has your child been on or is he/she now taking perscription medication? No Yes

Details: _____

Engagement with Allied Health Professionals

Please indicate (tick) past or present involvement with the following Health Professions

	Past	Present	Key focus & length of involvement
Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech therapist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your child been examined for the following:

If yes, when and results Hearing Test Eye Examination Tested for Allergies

3). Medical History

Has or does.... have:	Your Child		Family members		If yes list who _____
	No	Yes	No	Yes	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hayfever/allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/convulsions/fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech or Language difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Developmental difficulties such as Dyspraxia, ADHD, Autism Spectrum disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

4). Educational History - for children 3 years +

- A). Did / Does your child attend Kindergarten? No Yes if Yes, how many years _____
- B). Is your child attending or have they attended Learning Support Program (LSP) in school? No Yes
If Yes, length of time _____ Area in need of assistance: _____
- C). Has your child attended schools from different education systems? (e.g. Montessori, Public, Private) No Yes
Details: _____
- D). Is your child attending extra classes outside of school? (e.g. tuition) No Yes
If Yes, what is the focus & how often _____
- E). Has your child missed school for an extended period of time? No Yes
If Yes, length of time _____
- F). How does your child get along with teachers? Very well Ok Not well
Comments: _____
- G). How does your child get along with class mates? Very well Ok Not well
Comments: _____

5). Experiences

- A). Has your child witnessed any traumatic events (e.g. car collision, robbery, death of family member) No Yes
Comments: _____
-
- B). Has your child experienced any major stresses (e.g. divorce of parents, family illness, international relocation, bullying, death of a close friend/ family member) No Yes
Details _____
-

6). Parental Observations

A). Please indicate your current concerns: _____

B). Are these concerns? Recent Ongoing Comments _____

C). Which aspect(s) of daily living are being effected? Family relationships Learning Peer interactions
 Home routines Play / Activities Sleep

D). *Using this line, please indicate (mark) at what level your concern for your child is currently at:*

minimal concern, more inquisitive about child's behaviour	Concerned - noticing some changes in behaviour	Worried - many unexplained changes in behaviour	Very Worried, not sure how to cope
---	---	--	---------------------------------------

E). What do you hope to learn from engaging Dynamics Psychological Services? _____

F). What changes would you like to see in your child? _____

G). Please tick which of the following adjectives best describes your child's current behaviour (actions)

- | | | |
|--------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Compliant | <input type="checkbox"/> Slow | <input type="checkbox"/> Off Task |
| <input type="checkbox"/> Structured | <input type="checkbox"/> Erratic | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Very active | <input type="checkbox"/> Consistent | <input type="checkbox"/> Co-operative |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Agitated | <input type="checkbox"/> Spontaneous |
| <input type="checkbox"/> Restless | <input type="checkbox"/> Avoidant | <input type="checkbox"/> Other _____ |

H). Please tick which of the following adjectives best describes your child's mood for past 2 weeks

- | | | | |
|-------------------------------------|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Excited | <input type="checkbox"/> Confident | <input type="checkbox"/> Shy | Does their mood <i>change a lot</i>
depending on context (e.g.
home, school, time of day, day
of the week) |
| <input type="checkbox"/> Lethargic | <input type="checkbox"/> Cautious | <input type="checkbox"/> Lonely | |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Jealous | <input type="checkbox"/> Suspicious | |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Embarrassed | |
| <input type="checkbox"/> Joyous | <input type="checkbox"/> Bored | <input type="checkbox"/> Cheerful | |
| <input type="checkbox"/> Frustrated | <input type="checkbox"/> Anxious | <input type="checkbox"/> Exhausted | |
- No Yes