CHILD CLIENT HISTORY QUESTIONNAIRE

Today's Date: _____

Name of Child: _____ Date of Birth: _____
Age: ___

Home Address:
_____
Street City State Zip

Primary Phone:
_____
Secondary Phone:
_____

Ethnicity: _____
Language Spoken in Home: _____

Who referred you to Building Bridges Therapy Center?
_____

BBTC has permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation and/or sending report. ☐Y / ☐N

Caregiver(s):

Name: _____
Daytime Phone: _____
Relationship: ☐Mother ☐Father ☐Other: _____
Email Address:
_____
Occupation:
_____

Name: _____
Daytime Phone: _____
Relationship: ☐Mother ☐Father ☐Other: _____
Email Address:
_____
Occupation:
_____

Which caregiver completed this form? _____

Emergency Contact & Phone:

_____

_____

Home/Family Environment:

Marital Status:

☐ Not Married ☐ Married ☐ Separated ☐ Divorced ☐ Other

All persons living in the home:

Name	Age	Relation to patient	Highest grade completed

PREGNANCY AND BIRTH

While pregnant did child's mother have any of the following:

☐ German Measles
☐ Emotional Difficulties
☐ Anemia(low iron)
☐ Vaginal infection/bleeding
☐ Diabetes
☐ High blood pressure
☐ High fever
☐ Kidney problems
☐ Smoke cigarettes
☐ Drink alcohol
☐ Other:
_____

Were any medications taken during pregnancy? (include vitamins and iron)

Was the child born: ☐ early ☐ late ☐ on time

Was child born by C-section? ☐ Y / ☐ N

If yes, please give reason for C-section:

Approximately how long was mother in labor? _____ hours

What was baby's birth weight? _____ length?_____

Apgar Score?_____

What was baby's condition at birth?

ADOPTION

Child's age when adopted:

_____

Was child in foster care before adoption? ☐Y / ☐N

If so, how long? _____

Is child aware of his/her adoption? ☐ Y / ☐N

Describe the circumstances surrounding the adoption:

MILESTONES

Please provide a specific age or age range for the following:
At what age did child first:

Sit alone: _____
Feed self finger foods: _____
Crawl: _____
Speak first words: _____
Stand alone: _____
Put 2-3 words together: _____
Walk: _____
Become toilet trained: _____

MEDICAL AND DEVELOPMENTAL HISTORY

Child's Pediatrician/Family Doctor:

_____

Address:

_____

Street City State Zip

Please list any other medical doctors or clinics that have examined this child:

Name: Address: Purpose of Examination

_____

_____

_____

Date of Last Medical Checkup: _____
Height: _____
Weight: _____

Has child ever had the following:

☐ Eye or vision problems
☐ Ear/Hearing problems
☐ Food Allergies
☐ Seasonal Allergies
☐ Asthma
☐ Meningitis
☐ Convulsions or seizures
☐ Head Injury

Other health problems not listed above (describe)?

Does child take medication on a regular basis? ☐ Y / ☐ N

If yes, please list medication taken and amount:

Has the child ever been hospitalized? ☐ Y / ☐ N

Hospital Year Reason

_____

_____

_____

Has your child been diagnosed with any of the following:

- ☐ ADD/ADHD
- ☐ Cognitive Impairment
- ☐ Dyslexia
- ☐ Autism Spectrum Disorder
- ☐ Tourette's Syndrome
- ☐ Emotional Disorder (specify): _____
- ☐ Learning Disabilities (specify): _____
- ☐ Fragile X Syndrome
- ☐ Down Syndrome
- ☐ Sensory Processing Disorder or Sensory Integration Dysfunction
- ☐ Anxiety Disorder or Mood Disorder (specify): _____
- ☐ Other (specify): _____

PERTINENT PREVIOUS TESTING / THERAPEUTIC INTERVENTION

Please list other professionals currently involved with your child's care (Psychologist, Neurologist, Speech Language Pathologist, Occupational Therapist, BCBA, Ear Nose Throat Doctor, tutors etc.)

Name: _____
Title:_____ Phone: _____

Name: _____
Title:_____ Phone: _____

Name: _____
Title:_____ Phone: _____

EDUCATIONAL HISTORY

Is child currently enrolled in a school program? ☐ Y / ☐ N

If yes, please answer the following:

Name of School:

_____

Grade: _____ Type of Classroom: _____

Has child ever been evaluated by a school diagnostic team? ☐ Y / ☐ N

If yes, when was evaluation completed and what were the results?

Please describe the child's performance at school. What subjects does he/she do well in? What subjects are more difficult?

Does child receive any special services at school? If yes, please describe:

BEHAVIORAL CHARACTERISTICS

Which of the following describe your child:

- ☐ Cooperative
- ☐ destructive/aggressive
- ☐ attentive
- ☐ easily distracted/short attention span
- ☐ separation difficulties
- ☐ inappropriate behavior
- ☐ easily frustrated/impulsive
- ☐ self-abusive behavior

SOCIAL–EMOTIONAL DEVELOPMENT

Does your child exhibit behaviors at home or at school that concern you (describe)?

What methods are used to discipline child?

Are these methods effective? ☐ Y / ☐ N

What does your child like to do to occupy his/her time?

Does child have regular playmates or friends? ☐ Y / ☐ N

Does your child have access to an iPad or iPhone that they use regularly?

☐ Y/ ☐ N

If so, how much time per day (on average) does your child spend using this device?

_____

Is there anything else you would like for us to know about your child that was not covered above?

CURRENT STATUS

Please describe any difficulties your child has in the following areas:

Academic:

Activities of daily life (e.g., eating, dressing):

Relationships:

Sensory:

Motor:

Speech/Language:

Play:

Other:

OTHER

What are your child's strengths?

Is there anything else you would like for us to know about your child that was not covered above?

GOALS

What are your biggest concerns for your child at this time, and what changes do you hope to see in your child's development? How can the staff at Building Bridges help you most with these concerns? Please be as specific as possible.

_____
Client Name

_____
Parent/Guardian Signature Date

_____
Parent/Guardian 1 Signature Date