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Background Questionnaire

Family Data

Child's Name _____ Today's Date _____

Birth date _____ Age _____ Sex: Male Female

Home Address _____ Phone _____

School _____

Who referred you here? _____

Person filling out this form: Mother Father Stepmother Stepfather Both together Care giver

Other (please explain) _____

Mother's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Father's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

Stepparent's Name _____ Age _____ Education _____

Occupation _____ Phone: Home _____ Business _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers, sisters, or other significant people are living outside the home, list their names, ages, and relationships:

Primary language spoken in the home _____ Other languages spoken in the home _____

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

Name of child's physician _____

Presenting Problem

Briefly describe your child's current difficulties: _____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Have you noticed changes in the child's abilities? Yes No

If yes, please describe: _____

Have you noticed changes in the child's behavior? Yes No

If yes, please describe: _____

Has the child received evaluation or treatment for the current problem or similar problems? Yes No

If yes, when and with whom? _____

Is the child being treated for a medical illness? Yes No

If yes, for what condition is the child being treated? _____

Is the child on any medication at this time? Yes No If yes, please note kind of medication: _____

Social and Behavioral Checklist

Place a check mark next to any behavior or problem that your child currently exhibits.

- | | | |
|---|---|--|
| <input type="checkbox"/> Has difficulty with speech | <input type="checkbox"/> Has unusual or special fears, habits, or mannerisms (describe) _____ | <input type="checkbox"/> Does not understand other people's feelings |
| <input type="checkbox"/> Has difficulty with hearing | <input type="checkbox"/> Wets bed | <input type="checkbox"/> Has difficulty following directions |
| <input type="checkbox"/> Has difficulty with language | <input type="checkbox"/> Bites nails | <input type="checkbox"/> Gives up easily |
| <input type="checkbox"/> Has difficulty with vision | <input type="checkbox"/> Sucks thumb | <input type="checkbox"/> Takes drugs (describe) _____ |
| <input type="checkbox"/> Has difficulty with coordination | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Complains of aches or pains |
| <input type="checkbox"/> Has difficulty making friends | <input type="checkbox"/> Has frequent nightmares | <input type="checkbox"/> Is disobedient |
| <input type="checkbox"/> Has difficulty keeping friends | <input type="checkbox"/> Has trouble sleeping (describe) _____ | <input type="checkbox"/> Constantly seeks attention |
| <input type="checkbox"/> Refuses to share | <input type="checkbox"/> Rocks back and forth | <input type="checkbox"/> Is restless |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Bangs head | <input type="checkbox"/> Is jealous |
| <input type="checkbox"/> Does not get along well with brothers/sisters | <input type="checkbox"/> Holds breath | <input type="checkbox"/> Feels hopeless |
| <input type="checkbox"/> Does not get along well with other children | <input type="checkbox"/> Eats poorly | <input type="checkbox"/> Is nervous |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Is stubborn | <input type="checkbox"/> Does not show feelings |
| <input type="checkbox"/> Is shy or timid | <input type="checkbox"/> Has poor bowel control (soils self) | <input type="checkbox"/> Is immature |
| <input type="checkbox"/> Tires easily, has little energy | <input type="checkbox"/> Is much too active | <input type="checkbox"/> Is easily frustrated |
| <input type="checkbox"/> Is more interested in things (objects) than in people | <input type="checkbox"/> Is fidgety | <input type="checkbox"/> Requires constant supervision |
| <input type="checkbox"/> Engages in behavior that could be dangerous to self or others (describe) _____ | <input type="checkbox"/> Is easily distracted | <input type="checkbox"/> Has difficulty resisting peer pressure |
| _____ | <input type="checkbox"/> Is disorganized | <input type="checkbox"/> Shows anger easily |
| <input type="checkbox"/> Lies | <input type="checkbox"/> Is clumsy | <input type="checkbox"/> Has difficulty accepting criticism |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Has blank spells | <input type="checkbox"/> Feels sad, unhappy |
| <input type="checkbox"/> Injures self often | <input type="checkbox"/> Daydreams too much | <input type="checkbox"/> Has poor attention span |
| <input type="checkbox"/> Runs away | <input type="checkbox"/> Worries a lot | <input type="checkbox"/> Has poor memory |
| <input type="checkbox"/> Has low self-esteem | <input type="checkbox"/> Is impulsive | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Blames others for his or her troubles | <input type="checkbox"/> Takes unnecessary risks | <input type="checkbox"/> Is afraid of new situations |
| <input type="checkbox"/> Is argumentative | <input type="checkbox"/> Gets hurt frequently | <input type="checkbox"/> Eats inedible objects |
| <input type="checkbox"/> Fights with other children | <input type="checkbox"/> Has too many accidents | <input type="checkbox"/> Is not toilet trained |
| <input type="checkbox"/> Shows wide mood swings | <input type="checkbox"/> Doesn't learn from experience | <input type="checkbox"/> Other problem(s) (describe) _____ |
| | <input type="checkbox"/> Feels that he or she is bad | _____ |
| | <input type="checkbox"/> Is slow to learn | _____ |

Place a check mark next to any behavior problem that your child has shown within the last three months.

- | | | |
|--|---|---|
| <input type="checkbox"/> Shows sexually provocative behavior | <input type="checkbox"/> Refuses to sleep alone | <input type="checkbox"/> (In cases of divorce) Appears dazed, drugged, or groggy when returning from visiting a parent or caregiver |
| <input type="checkbox"/> Has extreme fear of bathroom or bathing | <input type="checkbox"/> Refuses to go to bed | <input type="checkbox"/> Other recent behaviors or problems (describe) _____ |
| <input type="checkbox"/> Has anxiety when separated from parents | <input type="checkbox"/> Has loss of bladder control | _____ |
| <input type="checkbox"/> Has extreme anxiety about going to school | <input type="checkbox"/> Is fearful of visiting a relative or going to a babysitter | |
| <input type="checkbox"/> Has fear at bedtime | <input type="checkbox"/> Is fearful of strangers | |
| | <input type="checkbox"/> (In cases of divorce) Is fearful of visiting a parent or caregiver | |

Educational History

Place a check next to any educational problem that your child currently exhibits.

- | | | |
|---|---|---|
| <input type="checkbox"/> Has difficulty reading | <input type="checkbox"/> Has difficulty paying attention | <input type="checkbox"/> Has difficulty getting along with teacher |
| <input type="checkbox"/> Has difficulty with arithmetic | <input type="checkbox"/> Has difficulty sitting still | <input type="checkbox"/> Has difficulty getting along with other children |
| <input type="checkbox"/> Has difficulty with spelling | <input type="checkbox"/> Has difficulty waiting turn | <input type="checkbox"/> Dislikes school |
| <input type="checkbox"/> Has difficulty writing | <input type="checkbox"/> Has difficulty respecting others' rights | |
| <input type="checkbox"/> Has difficulty with other subjects (please list) _____ | <input type="checkbox"/> Has difficulty remembering things | |

At what age did your child begin kindergarten? _____ What is his/her current grade? _____

Does your child receive Special Education services? Yes No If yes, what type _____

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's school performance become poorer recently? Yes No

If yes, please describe: _____

Has your child missed a lot of school? Yes No

If yes, please indicate reasons: _____

Developmental History

Pregnancy

Were there any problems during pregnancy? Yes No

If yes, what kind? _____

How old was the mother when she became pregnant? _____

Was this a first pregnancy? Yes No

(If no) How many times was the mother previously pregnant? _____

During pregnancy, did mother smoke Yes No If yes, How many cigarettes each day? _____

During pregnancy, did mother drink alcoholic beverages? Yes No

If yes, what did she drink? _____ Approximately how much alcohol was consumed each day? _____

During which part of pregnancy –1st trimester, 2nd trimester, 3rd trimester –was the alcohol consumed? _____

Were there times when 5 or more drinks were consumed at one time during pregnancy? Yes No

During pregnancy, did mother use drugs (including prescription, over the counter, and recreational)? Yes No

If yes, what kind? _____

During pregnancy, was mother exposed to any x-rays or chemicals? Yes No

If yes, what kind? _____

During pregnancy, was mother exposed to any infectious disease? Yes No

If yes, what kind? _____

During pregnancy, did mother receive prenatal care? Yes No

Was delivery induced? Yes No

How long was labor? _____ Were forceps used during delivery Yes No

Was a Caesarean section performed? Yes No If yes, for what reason? _____

Were there any complications associated with the delivery? Yes No

If yes, what kind? _____

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

Infancy

What was the child's birthweight? _____ 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: _____

Were there any other problems? Yes No

If yes, please describe: _____

As an infant, was the child quiet? Yes No As an infant, did the child like to be held? Yes No

As an infant, was the child alert? Yes No As an infant, did he or she grow normally Yes No

If no, please describe: _____

As an infant, was he or she different in any way from siblings? Yes No Not Applicable

If yes, please describe: _____

First Years

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

- Did not enjoy cuddling
- Excessive restlessness
- Constantly into everything
- Was not calmed by being held
- Poor sleep patterns
- Excessive number of accidents
- Colic
- Frequent head banging

Were there any other special problems in the growth and development of the child during the first few years? Yes No

If yes, please describe: _____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to mother	_____	Stood Alone	_____
Held head erect	_____	Walked alone	_____
Rolled over	_____	Ran with good control	_____
Sat alone	_____	Babbled	_____
Crawled	_____	Spoke first word	_____

Behavior	Age	Behavior	Age
Showed fear of strangers	_____	Took off clothing alone	_____
Put several words together	_____	Put on clothing alone	_____
Became toilet trained	_____	Tied shoelaces	_____
Stayed dry at night	_____	Rode tricycle	_____
Drank from a cup	_____	Named colors	_____
Fed self	_____	Said alphabet in order	_____
Played at Pat-a-cake, or Peek-a-boo	_____		

Child's Medical History

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

Illness or Condition	Age	Illness or Condition	Age	Illness or Condition	Age
<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Hospitalizations	_____	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> German measles	_____	<input type="checkbox"/> Operations	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Ear problems	_____	<input type="checkbox"/> Bone or joint disease ..	_____
<input type="checkbox"/> Chicken pox	_____	<input type="checkbox"/> Eye problems	_____	<input type="checkbox"/> Gonorrhea or syphilis ..	_____
<input type="checkbox"/> Whooping cough	_____	<input type="checkbox"/> Fainting spells	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Loss of consciousness .	_____	<input type="checkbox"/> Jaundice/hepatitis	_____
<input type="checkbox"/> Scarlet fever	_____	<input type="checkbox"/> Paralysis	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Frequent or severe	_____	<input type="checkbox"/> High blood pressure ...	_____
<input type="checkbox"/> High fever	_____	headaches	_____	<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> Difficulty concentrating	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Allergy	_____	<input type="checkbox"/> Memory problems	_____	<input type="checkbox"/> Bleeding problems	_____
<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> Extreme tiredness or ..	_____	<input type="checkbox"/> Eczema or hives	_____
<input type="checkbox"/> Injuries to head	_____	weakness	_____	<input type="checkbox"/> Suicide attempts	_____
<input type="checkbox"/> Broken Bones	_____	<input type="checkbox"/> Rheumatic fever	_____	<input type="checkbox"/> Sleeping problems	_____

Has your child had any other serious illnesses? Yes No If yes, what illness? _____

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

Has your child had any operations? Yes No If yes, please list reasons: _____

Has your child had any accidents? Yes No If yes, please describe: _____

Are your child's immunizations up to date? Yes No Child's height _____ Child's weight _____

Family Medical History

Place a check mark next to any illness or condition 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 of family member to child		Relationship of family member to child	
<input type="checkbox"/> Academic problem	_____	<input type="checkbox"/> Emotional problem	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart trouble	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Neurological disease	_____
<input type="checkbox"/> Developmental problem	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Other problems (Please list)	_____
<input type="checkbox"/> Drug problem	_____		_____

Other Information

Child's Activities

What are your child's favorite activities?

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

What activities would your child like to engage in more often than he/she does at present?

1. _____ 2. _____ 3. _____

What activities does your child like least?

1. _____ 2. _____ 3. _____

What chores does your child do around the house? _____

Has there been any recent change in his or her ability to carry out these chores? Yes No

If yes, please describe the change: _____

What time does your child usually go to bed on weekdays? _____ On weekends? _____

Trouble with the Law

Has your child ever been in trouble with the law? Yes No

If yes, please describe briefly: _____

Your Use of Disciplinary Techniques

What disciplinary techniques to you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There is also space for writing in any other disciplinary techniques that you use.

<input type="checkbox"/> Ignore problem behavior	<input type="checkbox"/> Redirect child's interest	<input type="checkbox"/> Other technique (describe) _____
<input type="checkbox"/> Scold child	<input type="checkbox"/> Tell child to sit on chair	_____
<input type="checkbox"/> Spank child	<input type="checkbox"/> Send child to his or her room	
<input type="checkbox"/> Threaten child	<input type="checkbox"/> Take away some activity or food	<input type="checkbox"/> Don't use any technique
<input type="checkbox"/> Reason with child		

Which disciplinary techniques are usually effective? _____

With what type of problem(s) _____

Which disciplinary techniques are usually ineffective? _____

With what type of problem(s) _____

Which parent usually administers discipline? _____

Child's Responsibilities

Can your child be trusted to care for a pet? Yes No

If no, why not? _____

Does your child handle his/her personal finances? Yes No

If not, why not? _____

Does your child take responsibility for his/her hygiene? Yes No

If not, why not? _____

Is the child's behavior generally age appropriate? Yes No

Please describe in what ways it is not age appropriate: _____

Other Areas

What do you enjoy doing with your child? _____

What have you found to be the most satisfactory way of helping your child? _____

What are your child's assets or strengths? _____

Is there any other information that you think may help us in working with your child? _____

What prompted you to seek help at this time? _____

Family Stress Survey

Every family sometimes experiences some form of stress. Please put a check next to each event that your family has experienced *in the last 12 months*. There is also a place for listing other types of stresses that your family experienced in the last 12 months.

- | | | |
|--|--|---|
| <input type="checkbox"/> Child's mother died | <input type="checkbox"/> Family moved to another part of town | <input type="checkbox"/> Child started having trouble with sisters/brothers |
| <input type="checkbox"/> Child's father died | <input type="checkbox"/> Someone in family was in trouble with the law or police (list person) _____ | <input type="checkbox"/> Child started having trouble in school |
| <input type="checkbox"/> Child's brother died | <input type="checkbox"/> Family's financial condition changed | <input type="checkbox"/> Child changed schools. |
| <input type="checkbox"/> Child's sister died | <input type="checkbox"/> Member of family was accused of child abuse or neglect (list person) _____ | <input type="checkbox"/> Child's close friend moved away |
| <input type="checkbox"/> Parents divorced | | <input type="checkbox"/> Child's pet died |
| <input type="checkbox"/> Parents separated | | <input type="checkbox"/> Other forms of stress _____ |
| <input type="checkbox"/> Grandparent died | | _____ |
| <input type="checkbox"/> Someone in family was seriously injured or became ill (list person) _____ | <input type="checkbox"/> Neighborhood was changing for the worse | _____ |
| <input type="checkbox"/> Parent remarried | <input type="checkbox"/> Child started having trouble with parents | _____ |
| <input type="checkbox"/> Father lost job | | |
| <input type="checkbox"/> Mother lost job | | |
| <input type="checkbox"/> Family moved to another city | | |

