



The Maple Counseling Center—Infant Mental Health Program
Family and Child Developmental Questionnaire

Parent's Name _____ **DOB:** _____ **SS#** _____

Address _____ **City, State, Zip** _____

Phone: H _____ **W** _____ **# of Household Members:** _____
(OK to say TMCC? Yes _____ No _____)

Parent's Name _____ **Age** _____ **Birthdate** _____

Address _____ **City, State, Zip** _____

Phone: H _____ **W** _____ **# of Household Members:** _____
(OK to say TMCC? Yes _____ No _____)

Child's Name _____ **DOB:** _____ **School:** _____

Grade Level _____ **Teacher** _____ **Pediatrician** _____

Child lives with _____

Child Ethnicity—Circle One:

- | | | | | | | |
|------------------------------------|----------------------|-------------------------|---------|----------------------|--------------------------------------|---------|
| African, African-American/Black | Asian & African-Amer | Hispanic origin, Latino | Unknown | African-Caucasian | Asian, Pacific Islander | Iranian |
| Unwilling to be identified by race | African-Hispanic | Asian-Amer. | Israeli | White, Indo-European | Amer Indian, Native American, Eskimo | |
| Asian-Hispanic | Korean | | | | | |

Child's Name _____ **DOB:** _____ **School:** _____

Grade Level _____ **Teacher** _____ **Pediatrician** _____

Child lives with _____

Child Ethnicity—Circle One:

- | | | | | | | |
|------------------------------------|----------------------|-------------------------|---------|----------------------|--------------------------------------|---------|
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| Asian-Hispanic | Korean | | | | | |

Child's Name _____ **DOB:** _____ **School:** _____

Grade Level _____ **Teacher** _____ **Pediatrician** _____

Child lives with _____

Child Ethnicity—Circle One:

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| Asian-Hispanic | Korean | | | | | |

FAMILY HISTORY

Marital status of parents _____

For parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements.) Who has legal custody? _____

Is ex-spouse (biological parent) aware that you bring their children to TMCC? Yes _____ No _____

If child is not with biological parents, when did separation occur? _____

If adopted, does child know of adoption? Yes _____ No _____

What age was your child at the time of adoption? _____

What is the current living situation? _____

What significant events have your family experienced {moves, separations, deaths}? _____

Mother's Name _____ Age _____

Ethnicity _____ Occupation? _____ Hrs. per week? _____

Significant medical problems? _____

Serious illnesses, accidents, or surgeries in the past? _____

Medications currently prescribed? _____

History of psychiatric treatment or counseling? _____

Current alcohol or drug use (how often, intoxication frequency)? _____

History of alcohol or drug abuse? _____

Close relatives with drug/alcohol problems or mental illness? _____

History of arrests? _____

Father's Name _____ **Age** _____

Ethnicity _____ Occupation? _____ Hrs. per week? _____

Significant medical problems? _____

Serious illness, accidents, or surgeries in the past? _____

Medications currently prescribed? _____

History of psychiatric treatment or counseling? _____

Current alcohol and drug use (how often, intoxication frequency)? _____

History of drug/alcohol abuse? _____

Close relatives with drug/alcohol problems or mental illness? _____

History of arrests? _____

Step-parent or guardian name _____ **Age** _____

Occupation? _____ Significant medical problems? _____

Serious illness, accidents, or surgeries in the past? _____

Medications currently prescribed? _____

History of psychiatric treatment or counseling? _____

Current alcohol and drug use (how often, intoxication frequency)? _____

History of drug/alcohol abuse? _____

Close relatives with drug/alcohol problems or mental illness? _____

History of arrests? _____

SCHOOL AND AGENCY INFORMATION

Did/does child attend preschool? _____ Beginning at what age? _____

Were there any problems? _____

Does child have behavior problems now in school? _____

Does child have learning problems in school? _____

If child has been kept back or put ahead in school, please explain _____

If child has been in special classes, please explain _____

Since what age? _____

If child has ever been excluded from school, explain when and why _____

Are there any other agencies involved with the family? (DCS, Child Welfare, etc.) _____

MEDICAL HISTORY OF THE CHILD

Has child ever had any serious illnesses, ear infections, allergies, accidents, or operations? _____

Please describe and specify child's age at the time (include any present illnesses) _____

Pediatrician's name and address _____

Phone _____ Currently on medication? If yes, what _____

Has child been immunized? Up to date on immunizations? _____

Has child ever had psychiatric treatment? If yes, please give details _____

HISTORY OF PROBLEM

In your own words, please describe any present difficulties that child is having or that you may be having as parent(s): _____

What methods were used in trying to help with these problems? _____

In what way do you think I can help you? _____

CHILD'S DEVELOPMENTAL HISTORY

A. Period during Pregnancy

Was the child planned? _____ Sex preference? _____

When was pregnancy discovered? _____

How did mother feel about having child? _____

Did mother have any medical or emotional problems during pregnancy (for example, diabetes, bedridden, unusual nervousness, depression)? _____

Did mother receive prenatal care? Starting when/how often? _____

How did father feel about having child? _____ Sex preference? _____

Did mother work during pregnancy? _____ How long? _____

B. Details of Labor and Delivery

Vaginal or C-section birth? _____ Where was child born? _____

Any complications in labor or delivery? _____

Did mother experience any “blues” after child’s birth? _____

C. Postnatal

Weight of child at birth _____ Was child full term (9 months)? _____

Any complications after child was born? (difficulty breathing, low apgar score, jaundice) _____

Did mother have help at home after delivery? For how long? _____

During child’s birth year, was there anything (even if it had nothing to do with child) that caused mother unhappiness or anxiety or that placed her under great strain? _____

After child’s birth, how soon did mother return to work? _____

How many hours per week? _____

If mother was working, who had primary caretaking responsibility? _____

Who currently cares for the child if parents are away? (please include history of caregivers other than parents from birth to the present) _____

Was child ever separated from both parents? _____ One parent? _____

Describe circumstances (reason, child’s age at the time, and how long) _____

What part did father take in child’s care? (diapering, bathing, feeding, etc.) _____

D. Feeding

Breastfed? _____ When was child weaned? _____ Why did weaning occur at that time? _____

Bottlefed? _____ When was child weaned? _____

Why did weaning occur at that time? _____

Were there any feeding problems? (colic, reflux, allergies) _____

Any thumb or pacifier sucking? For how long? _____

E. Sleep Patterns

Were there any sleeping problems? If yes, please explain _____

Has child ever slept with parents? Please describe circumstances _____

Present sleeping arrangements _____

F. Motor Development

Was child ever perceived as too active or too quiet? Please describe _____

At what age did child begin to sit? _____ Stand? _____ Walk? _____ Who took primary

responsibility for toilet training? _____ At what age was bladder training begun? _____

When completed for day? _____ For nights? _____ Method used? _____

At what age was bowel training begun? _____ Completed? _____ Method? _____

Was toilet training ever a problem? _____

Is this a problem at present? _____

Is child primarily right or left handed? _____

G. Speech Development

At what age did child first begin to speak in short (2 or more words) sentences? _____

If there have been any of the following speech difficulties, please check:

Does not talk _____ Lispings _____ Delayed speech _____

Repeating syllables _____ Mispronounced words _____ Stuttering _____

Other, please describe: _____

Has child ever had speech therapy? With whom? _____

H. Sexual Development

Has child expressed curiosity about any sexual matters to a parent? _____ About what? _____

Has child been given information by a parent in any of the following areas? Please check.

Difference between boys/girls _____ How a woman becomes pregnant _____

How child develops and is born _____ Menstruation _____ Birth control _____ Intercourse _____

I. Peer Interests

Does child have trouble making friends? Please describe. _____

Does child make friends mostly with children his or her own age? _____ Younger? _____ Older? _____

Describe any special interests or hobbies? _____

J. Other

Does infant ever cry for extended periods? _____ If yes, how do you respond? _____

How is discipline usually handled with child? _____

Do you have any other questions, concerns, comments on the questionnaire or additional information you would like me to know? _____

Please check ALL times you are available for therapy:

Mon: 8 - 12 _____ 12 - 5 _____ 5 - 9 _____

Thurs: 8 - 12 _____ 12 - 5 _____ 5 - 9 _____

Tues: 8 - 12 _____ 12 - 5 _____ 5 - 9 _____

Fri: 8 - 12 _____ 12 - 5 _____

Wed: 8 - 12 _____ 12 - 5 _____ 5 - 9 _____

Sat: 9-1 _____

Name _____

Please circle the symptoms you are currently experiencing:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sadness or Depression	0	1	2	3	Memory Problems	0	1	2	3
Suicidal Thoughts	0	1	2	3	Compulsive Behavior	0	1	2	3
Sleep Problems	0	1	2	3	Feelings of Hostility	0	1	2	3
Change in Appetite	0	1	2	3	Acts of Violence	0	1	2	3
Weight Change	0	1	2	3	Social Isolation	0	1	2	3
Inability to Concentrate	0	1	2	3	Strange Thoughts	0	1	2	3
Obsessive Thoughts	0	1	2	3	Sexual Problems	0	1	2	3
Tension/Anxiety	0	1	2	3	Panic Attacks	0	1	2	3

1. Please circle the number which best describes how well you are doing in your relationship with your child:

0	1	2	3	4	5	6	7	8	9
Not	Cannot		Serious		Moderate		Mild		No
Working	Function		Problems		Problems		Problems		Problems

2. Please circle the number which best describes how well you are doing in your marital/significant other relationship:

0	1	2	3	4	5	6	7	8	9
Not	Cannot		Serious		Moderate		Mild		No
Working	Function		Problems		Problems		Problems		Problems

3. Please circle the number which best describes how well you are doing in your family relationships:

0	1	2	3	4	5	6	7	8	9
Not	Cannot		Serious		Moderate		Mild		No
Working	Function		Problems		Problems		Problems		Problems

4. Please circle the number which best describes how well you are doing in relationships with people outside your family:

0	1	2	3	4	5	6	7	8	9
Not	Cannot		Serious		Moderate		Mild		No
Working	Function		Problems		Problems		Problems		Problems

5. Please circle the number which best describes how well you are doing in your job or at school:

0	1	2	3	4	5	6	7	8	9
Not	Cannot		Serious		Moderate		Mild		No
Working	Function		Problems		Problems		Problems		Problems

6. Please circle the number which best describes your current physical health:

0	1	2	3	4	5	6	7	8	9
Very	Poor								Excellent

7. Please circle the number which best describes your general happiness and well-being:

0	1	2	3	4	5	6	7	8	9
Very	Poor								Excellent