



## EARLY DEVELOPMENT

1. Were there any problems with the pregnancy with this child?    **YES**    **NO**    **DON'T KNOW**

2. Was your child exposed to any possible harmful substances during the pregnancy (alcohol, tobacco, drugs, etc.)?    **YES**    **NO**    **DON'T KNOW**

3. Were there any problems for the mother with the delivery?    **YES**    **NO**    **DON'T KNOW**

4. Did your child have any medical complications at the time of the birth?  
**YES**    **NO**    **DON'T KNOW**

5. Was your child excessively active or difficult as a baby?    **YES**    **NO**    **DON'T KNOW**

6. Were there any problems with your child's early development (walking, talking, toilet training, etc.)?    **YES**    **NO**    **DON'T KNOW**

7. Has your child had any problems with fine motor skills (holding small objects, handwriting, etc.)?  
**YES**    **NO**    **DON'T KNOW**

8. Has your child had any problems with gross motor skills (clumsiness, difficulty with athletics, etc.)?    **YES**    **NO**    **DON'T KNOW**

## HEALTH

9. Has your child suffered any serious illness?    **YES**    **NO**    **DON'T KNOW**

10. Does your child suffer from any allergies?    **YES**    **NO**    **DON'T KNOW**

11. Does your child have any unusual eating habits?    **YES**    **NO**    **DON'T KNOW**

12. Does your child have frequent stomach/digestion problems?    **YES**    **NO**    **DON'T KNOW**

13. Has your child ever had a serious head injury?    **YES**    **NO**    **DON'T KNOW**

14. Does your child often complain of headaches?    **YES**    **NO**    **DON'T KNOW**

15. Does your child have dizzy spells or frequently stare into space?    **YES**    **NO**    **DON'T KNOW**

<b>16. Does your child frequently start to say something and then forget what he/she was saying?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>17. Does your child have any nervous tics, twitches, or habits?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>18. Does your child's memory seem to have changed recently?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>19. Does your child's walk seem to have changed recently?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>SLEEPING</b>			
<b>20. Does your child have any difficulties going to bed or sleeping?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>21. Does your child sleep-walk?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>22. Does your child have frequent nightmares?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>23. Does your child frequently fall deeply asleep well before bedtime?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>24. Does your child frequently wet the bed?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>EMOTIONAL</b>			
<b>25. Has your child or other family member had any previous psychological testing or counseling?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>26. Has your child ever had a significant emotional trauma?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>27. Is there a history of any emotional problems, alcoholism or learning problems in the biological mother or on her side of the family?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>28. Is there a history of any emotional problems, alcoholism or learning problems in the biological mother or on her side of the family?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	
<b>29. Is there a history of any emotional problems, alcoholism or learning problems in any of the child's siblings?</b>			
<b>YES</b>	<b>NO</b>	<b>DON'T KNOW</b>	

**SOCIAL**

**30. Does your child have problems with making and keeping friends?    YES    NO  
DON'T KNOW**

**31. Are you displeased with the type of friends your child associates?    YES    NO  
DON'T KNOW**

**32. Has your child ever used drugs or alcohol?    YES    NO    DON'T KNOW**

**33. Has your child ever been in any legal difficulty?    YES    NO    DON'T KNOW**

**EDUCATION**

**34. Is your child having difficulty in school?    YES    NO    DON'T KNOW**

**35. Is your child in any special classes in school?    YES    NO    DON'T KNOW**

**Briefly, what would you like to see accomplished by having your child receive counseling?**

**Is there any special information that should be known about your child?**