STUDENT SERVICES
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PSYCHOLOGICAL SERVICES
BACKGROUND INFORMATION FORM

Please complete as much of this questionnaire as you can. It may help to identify the source of your child's difficulties. Only persons directly involved in the assessment process will see the information that you include, but you are free to leave out sections if you wish. Information that you do not want included in the psychological report can be marked in some way (e.g., circled, crossed out, etc.). You may also decide to include information not requested on the form. This questionnaire comes with a large self-addressed envelope. After completing the form, please seal it in the envelope, and either mail it back or return it to your child's resource teacher.

A. IDENTIFYING INFORMATION:

NAME OF CHILD: _____ AGE _____ SEX _____

DATE OF BIRTH: _____ NATURAL _____ ADOPTED _____ FOSTER _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

NAME(S) OF PARENTS LIVING AT HOME: _____

_____

NAME(S) & AGE(S) OF CHILD'S SIBLINGS: _____

_____

_____

IF FOSTER, CHILD'S SOCIAL WORKER: _____

LANGUAGE(S) SPOKEN AT HOME: check all that apply & indicate how much time for each:

Spoken by Parents			**Spoken by Children**		
Checkmark ✓	**Language**	**% of Time**	**Checkmark ✓**	**Language**	**% of Time**
	English			English	
	French			French	
	German			German	
	Low German			Low German	
	Spanish			Spanish	
	Other *			Other *	

*Other language spoken at home = _____

B. FAMILY HISTORY:

1. Have you or your spouse been previously married or lived common law?
   Yes ____ No ____ If yes, please specify: _____
   _____
2. Are you currently separated ____ or divorced ____? If so, when did this occur?
   (Specify): _____
3. Who has legal custody of the referred child?_____
4. If separated or divorced, describe the child visitation privileges: _____
   _____
5. If currently married, how long have you been together? _____
6. How many residential moves has your child experienced? _____
7. Have you or your spouse experienced any recent job loss? Yes ____ No ____. If yes, please specify: _____
8. Has anybody your child was close to died within the last year? Yes ____ No ____. If yes, please specify: _____
9. Has anybody in the child's family (immediate or extended) ever been diagnosed with a mental disorder or serious illness? Yes ____ No ____. If yes, please Specify:_____
   _____
   _____
10. Has anybody in the child's family (immediate or extended) ever had a learning disability of some sort? Yes ____ No ____. If yes, please specify: _____
    _____
    _____
11. If currently married or living common law, estimate the average degree of adult partner conflict experienced by the referred child over the past month by selecting a rating anywhere from 1 (very low) to 10 (very high): _____.
12. Has your child ever experienced any emotional trauma or abuse? Yes ____ No ____. If yes, please specify: _____
    _____
    _____
13. How well does your child get along with other family members? _____
    _____
    _____

15. List the types of chores for which your child is responsible at home: _____

_____

_____

16. How well does your child carry out his/her chores at home? _____

_____

17. What behaviour problems does your child exhibit at home or in the community?

_____

_____

_____

_____

18. What types of disciplinary strategies do you use at home with your child to promote respectful and responsible behavior? _____

_____

_____

_____

19. How well do the disciplinary strategies work? _____

20. Please complete the educational data for each biological parent:

	Biological Father	**Biological Mother**
(A) Name	_____	_____
(B) Highest grade completed in school	_____	_____
(C) Post secondary education	_____	_____
(D) Learning problems	_____	_____
(E) Occupation	_____	_____

21. Does your child have any difficulties completing homework? Yes ____ No ____. If yes, Please specify: _____

_____

22. Is your child spending a reasonable amount of time at home studying for tests and exams? Yes ____ No ____. If yes, is the time spent studying paying off in expected marks at school? _____

23. What does your child do when attempting to study for tests or exams? _____

_____

_____

24. Does anyone help your child with homework or studying? Yes ___ No ___. If yes, what assistance is provided? _____

_____

25. Does your child get any private tutoring outside of school? Yes ___ No ___.
If yes, who provides the tutoring? _____
What subjects or academic skills are tutored? _____
How often does your child get tutored? _____
If tutored in the past, state who, when, and for what: _____

_____

C. DEVELOPMENTAL HISTORY:

1. Biological mother's age during pregnancy: _____ yrs.
2. Was this a planned _____ or unplanned _____ pregnancy?
3. What did the pregnancy mean to the child's mother? _____

_____

4. Did the mother have a fever, infectious disease, or health problems during pregnancy? Yes ____ No ____ If yes, please specify _____

_____

5. Was any tobacco, alcohol, or illicit drug used during the pregnancy? Yes ____ No ____
If yes, please specify substance & quantity: _____

_____

6. Was there any reported fetal distress during labor? If yes, please describe: _____

_____

7. Were there any complications during labor or delivery (e.g., breech birth, umbilical cord around neck, forceps delivery, cesarean section)? Yes ____ No ____ If yes, please specify_____

8. Was child born (a) full term ____ (b) premature ____ (c) late ____? If (b) or (c) please specify by how much:_____

8. Child's birth weight: _____ Any severe jaundice? _____

10. Did the child have any colic? Yes ____ No ____. If yes, how long? _____

    Did anyone shake the baby during this time? _____

11. *Motor Development*: Please state age, if known, or whether development was slow, average, or early.

    (a) sitting _____ (b) crawling _____

    (c) standing _____ (d) walking _____

12. *Speech Development*: Please state age, if known, or whether development was slow, average, or early.

    (a) first words _____

    (b) sentences _____

13. At what age was the child toilet trained? _____ yrs. Were there any difficulties (e.g., bed-wetting, daytime wetting, soiling, etc.?) If yes, specify: _____

    _____

    Does your child still have difficulties? Yes ___ No ___ How are you treating it? _____

    _____

14. Did the child as a preschooler repeatedly try to share with his/her parent(s) newly discovered things, interests, and achievements? Yes ____ No ____. Does this occur now? Yes ___ No ____.

D. MEDICAL HISTORY:

1. Did the child have any severe illnesses, accidents, hospitalizations, or operations?

   Yes ____ No ____ If yes, please specify: _____

   _____

2. Did the child ever have high fever, convulsions, seizures, or blank spells?

   Yes ____ No ____ If yes, please specify: _____

   _____

3. Did the child ever get knocked unconscious or have a concussion? Yes ___ No ___. If so, what caused it and how long did it last? _____

4. Did the child ever have a brain scan (e.g., CT, MRI, EEG)? If so, what were the results?

   _____

   _____

4. Did the child have ear infections?

   Yes ____ No ____ If yes, please specify: _____

   _____

5. Did the child have allergies? Yes ____ No ____ If yes, please specify: _____

_____

6. Does the child have any difficulties sleeping (e.g., falling or staying asleep, waking early, snoring, sleep walking, getting up on time, etc.)?_____

_____

7. Did the child ever have any poisoning from lead or other toxins (e.g., from eating old paint chips, soil, mercury, etc.)? _____

8. Has the child received any medical diagnoses? Yes ____ No ____ If yes, please specify:

_____

9. Has the child ever been prescribed any medication? If yes, please specify: _____

_____

10. Please list the names of the child's medical doctor, any other specialists, and their phone numbers: _____

_____

E. SPECIAL SUPPORT SERVICES:

1. Has your child had a thorough visual examination? Yes ____ No ____.
   If yes, where _____ When _____
   Results: _____
2. Has your child had a thorough hearing assessment? Yes ____ No ____.
   If yes, where _____ When _____
   Results: _____
3. Does your child have any physical handicaps? Yes ____ No ____.
   If yes, please specify: _____

   _____
4. Please note if your child has received services in the following areas:
   (a) Speech Therapy: Yes ____ No ____
   If yes, where _____ When _____
   (b) Psychological Assessment: Yes ____ No ____
   If yes, where _____ When _____
   (c) Social Work/Counselling: Yes ____ No ____
   If yes, where _____ When _____
   (d) Occupational Therapy: Yes ____ No ____
   If yes, where _____ When _____

(e) Physiotherapy: Yes ____ No ____

If yes, where _____ When _____

(f) Mental Health/Psychiatry: Yes ___ No ___

If yes, where _____ When _____

F. EDUCATIONAL HISTORY:

1. Please list your child's schools in order of attendance.

Name of School	Age	Grades	Special or Regular Class	Best Subjects	Worst Subjects

2. How has your child's school attendance been (e.g., regular, missed blocks of time, refusals, truant, etc.)? _____

_____

3. Has your child been misbehaving in school? Yes ____ No ____. If yes, please specify:

_____

_____

4. Has your school used any special motivational or disciplinary strategies to try and change any of your child's behaviors? Yes ____ No ____. If yes, please specify: _____

_____

_____

6. Has your child received any resource help in school? Yes ____ No ____. If yes, please specify: _____

_____

7. Has your child's school tried any instructional adaptations or modifications to allow for a greater chance of academic success? Yes ____ No ____. If yes, please specify: _____

_____

_____

8. How much does your child like school on a scale from 1 (Low) to 10 (High)? _____

9. What kind of job does your child hope to get after finishing school? _____

_____

G. CHILD'S PERSONALITY:

1. Please list the strengths, talents, and interests of your child: _____

_____

_____

_____

_____

_____

2. Please put an "✓" over the point along each continuum below that best describes your child.

A.) ***Temperamental Traits*** **(starting from early on, when child was a toddler):**

Low Activity Level	____:____:____:____:____:____:____	High Activity Level
High Persistence	____:____:____:____:____:____:____	Low Persistence
Gentle	____:____:____:____:____:____:____	Forceful
Positive Moods	____:____:____:____:____:____:____	Negative Moods
Approaches Novelty	____:____:____:____:____:____:____	Avoids Novelty
Reflective	____:____:____:____:____:____:____	Impulsive
Normal Senses	____:____:____:____:____:____:____	Irritable Senses*

NOTE: "*Irritable Senses*" – some children are sensitive or easily irritated by how things feel, smell, taste, sound, etc. They may communicate displeasure to caregivers, try to escape irritating situations, or avoid them. They may be exceptionally sensitive in some sensory channels (e.g., touch or hearing) but not as much in others (e.g., smell or taste). Other children with normal senses are not bothered much by how things feel, smell, taste, sound.

*If child has irritable senses, which channels are affected? Hearing___? Vision___? Touch ___? Taste ___? Smell ___? What problems result from this? _____

_____

_____

H. EXTRA-CURRICULAR INVOLVEMENT:

1. Please list your child's hobbies: _____

_____

_____

_____

2. Please list the types of sports with which your child is involved: _____

_____

3. Please list the organizations (e.g., clubs, teams) of which your child is a member:

_____

4. Please list the type of private lessons (e.g., piano, skating) your child is taking:

_____

5. How popular would you say your child is in school with other children on a scale from 1 (very unpopular) to 10 (very popular): _____
6. Does your child have any difficulty getting along with peers? _____

_____

7. About how many close friends does your child have? _____
8. How frequently does your child see his/her friends per week? _____
9. What does your child like to do with his/her friends? _____

_____

10. Has your child ever been bullied? _____

I. OTHER RELEVANT INFORMATION:

1. What concerns you most about your child's current functioning? _____

_____

_____

_____

_____

_____

2. When did the problem(s) about which you are concerned begin? How old was your child at the time? _____

_____

3. Please formulate your own ideas about the suspected cause of your child's problem(s):

_____

_____

_____

_____

_____

_____

4. What outcome would you like to see happen as a result of this referral?

_____

_____

_____

_____

FORM COMPLETED BY (NAME): _____

DATE: _____

THANK YOU FOR THIS INFORMATION

This personal information, or personal health information, is being collected under the authority of Hanover School Division and will be used for educational purposes or to ensure the health and safety of the student. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act and The Personal Health Information Act. If you have any questions about the collection, contact the Hanover School Division Access and Privacy Coordinator at 326-9829.