INNERACTION Therapy for Inner Well-Being and Interpersonal Success

FAMILY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a history of your child's life. The information that you are able to give me will aid me in coming to a better understanding of your child's present problems so that I may be of help to you and him/her. By law, all information provided will be treated as privileged and confidential and will not be released to others without your written permission or request. If you feel uncomfortable answering any questions please leave them blank and discuss this during your appointment time.

I. General Information

A. Name (individual completing this form): _____
Address: _____
Telephone Numbers: Day _____Evening_____
Age: _____ Occupation: _____
Relationship to individual to be seen: _____

B. Name (individual to be seen):_____
Address: _____
Birthdate:_____

C. Referred by:_____

II. Family Background - Child is being raised by:

A. Natural Parents_____ Parent and Stepparent_____
Adoptive Parents _____ Foster Parents _____
Date of Marriage _____
Single parent_____ Relatives _____
Institution _____ Other _____

B. Present Family
Female head of household _____
Birthdate: _____ Relation to child: _____
Address: _____
Phone: Cell: _____Work: _____
Occupation: _____Employer:_____
Previous mental health treatment: Yes _____ No_____ Where: _____
Education: Circle last grade attended: 1 2 3 4 5 6 7 8 9 10 11 12
College: _____ Degree: Yes _____No _____

Male head of household _____
Birthdate: _____ Relation to child: _____
Address: _____
Phone: Cell: _____Work: _____
Occupation: _____Employer:_____
Previous mental health treatment: Yes _____ No_____ Where: _____
Education: Circle last grade attended: 1 2 3 4 5 6 7 8 9 10 11 12
College: _____ Degree: Yes _____No _____

FAMILY QUESTIONNAIRE (cont.)

Present Family Make-up (list all people living in the household)

Name Relationship to Child Age

_____

_____

_____

_____

_____

C. Marital status of Natural Parents:

Married, living together: _____ Never married: _____

Separated: _____ Mother remarried: _____

Parents divorced: _____ Father remarried: _____

One Parent Deceased: _____ Both parents deceased: _____

Other (specify): _____

D. Information on one or both natural parents if child is not presently living with them:

Mother _____Birthdate _____Number of marriages _____

Address _____ City _____State_____

Phone _____ Occupation: _____

Education 1 2 3 4 5 6 7 8 9 10 11 12 College: _____Degree _____

Previous mental health treatment: Yes_____ No_____ Where: _____

Father _____Birthdate _____Number of marriages _____

Address _____ City _____State_____

Phone _____ Occupation: _____

Education 1 2 3 4 5 6 7 8 9 10 11 12 College: _____Degree _____

Previous mental health treatment: Yes_____ No_____ Where: _____

E. Other persons with whom this child has lived:

Name_____ Relationship _____When_____

Name_____ Relationship _____When_____

Name_____ Relationship _____When_____

F. Paternal/Maternal Grandparents

	Paternal Grandfather	Paternal Grandmother
Living?	Yes _____ No _____	Yes_____ No _____
If alive, present age	_____	_____
Occupation	_____	_____
Current health	_____	_____
If deceased, your age at time of his/her death	_____	_____

FAMILY QUESTIONNAIRE (cont.)

	Maternal Grandfather	Maternal Grandmother
Living?	Yes _____ No _____	Yes_____ No _____
If alive, present age	_____	_____
Occupation	_____	_____
Current health	_____	_____
If deceased, your age at time of his/her death	_____	_____

III Information on Individual to be Seen:

Prenatal and Newborn:

Prenatal

		Yes	No
A.	Have there been miscarriages?	Yes_____	No _____
B.	Was mother's health poor during pregnancy?	Yes_____	No _____
C.	Was there difficulty in carrying the child to term?	Yes_____	No _____
D.	Was mother unusually emotional or depressed during pregnancy?	Yes_____	No _____
E.	Did mother have any illnesses during pregnancy?	Yes_____	No _____
F.	Did mother incur accident or injury during pregnancy?	Yes_____	No _____

Newborn

1.	Was birth premature? (7 months or less, 5# or less)	Yes_____	No _____
2.	Was labor prolonged? (12hrs or longer)	Yes_____	No _____
3.	Were forceps used?	Yes_____	No _____
4.	Was this a Caesarian Section?	Yes_____	No _____
5.	Was your child in an incubator?	Yes_____	No _____
6.	Was this a breech complication?	Yes_____	No _____
7.	Were there any complications at birth or shortly thereafter with your child?	Yes_____	No _____
8.	Were there any complications at birth or shortly thereafter with the mother?	Yes_____	No _____

Development History - Infancy and Early Childhood

1. When did the baby turn over? _____
2. When did the baby sit alone if placed in this position? _____
3. When did the baby get into a sitting position unaided? _____
4. When did the baby crawl? _____
5. When did he/she walk? _____
6. When did he/she learn to undress, put on outer garments, manage buttons, zippers, laces?
   _____
7. When was he/she toilet trained, bladder and bowel, day and night? _____

FAMILY QUESTIONNAIRE (cont.)

8. When did he/she use single words, phrases, and sentences? _____
9. Did you experience/encounter difficulty in these areas of training? Yes_____ No _____
10. Did your child have early feeding problems? Yes_____ No _____
11. Has your child ever seemed unusually clumsy? Yes_____ No _____
12. Did speech begin to develop and then stop? Yes_____ No _____
13. Has your child wet the bed beyond the usual age? Yes_____ No _____
14. Is your child susceptible to small accidents or injury? Yes_____ No _____
15. Does your child seem to need more or less sleep than most children? Yes_____ No _____
16. Does your child seem not to learn as quickly as others? Yes_____ No _____

General Health Information

1. Is your child under medication at present? Yes_____ No _____
2. Has your child ever been under sustained medication? Yes_____ No _____
3. What medication(s) is/are your child taking? Please include dose and frequency:_____

   _____

   _____
4. What supplements is your child taking? Please include dose and frequency: _____

   _____

   _____
5. Has your child ever been hospitalized? Yes_____ No _____
6. Has your child ever had any surgery? Yes_____ No _____
7. Has your child ever had any illness with a high or prolonged fever? Yes_____ No _____
8. Has your child experienced any seizures, with or without fever? Yes_____ No _____
9. Has your child been much underweight? Yes_____ No _____
10. Has your child been much overweight? Yes_____ No _____
11. Has your child ever had episodes of twitching or shaking? Yes_____ No _____
12. Does your child's nose appear stuffed up without apparent cold? Yes_____ No _____
13. Was your child ever knocked unconscious? Yes_____ No _____
14. Would you say your child is or was a 'sickly' child? Yes_____ No _____
15. Does your child have any physical abnormalities? Yes_____ No _____
16. Does your child have any physical complaints and/or conditions not already mentioned?
    Describe: _____

    _____

    _____

    _____

FAMILY QUESTIONNAIRE (cont.)

17. Has your child had:

Chicken Pox	Yes_____	No_____	Seizures	Yes_____	No _____
Measles	Yes_____	No_____	Convulsions	Yes_____	No _____
Mumps	Yes_____	No_____	Vomiting Spells	Yes_____	No _____
Scarlet Fever	Yes_____	No_____	Fainting Spells	Yes_____	No _____
Whooping Cough	Yes_____	No_____	Dizzy Spells	Yes_____	No _____
Allergies	Yes_____	No_____	Nose Bleeds	Yes_____	No _____
Asthma	Yes_____	No_____	Constipation	Yes_____	No _____
Pneumonia	Yes_____	No_____	Frequent Colds	Yes_____	No _____
Encephalitis	Yes_____	No_____	Ear Infections	Yes_____	No _____
Polio	Yes_____	No_____	Frequent Diarrhea	Yes_____	No _____
Rheumatic Fever	Yes_____	No_____	Abnormal EEG	Yes_____	No _____
Chorea	Yes_____	No_____	Stomach Complaints	Yes_____	No _____
Meningitis	Yes_____	No_____	Other _____		

Family Relationships

1. Child's relationship with family members: Give a description of the child's behavior and attitude toward:
   a. FATHER: Positive / strengths:

      Negative / weaknesses:

   b. MOTHER: Positive / strengths:

      Negative / weaknesses:

   c. SIBLINGS: Positive / strengths:

      Negative / weaknesses:

   d. OTHERS: Positive / strengths:

      Negative / weaknesses:

FAMILY QUESTIONNAIRE (cont.)

2. Specific member's relationship with child: Give a description of each individuals behavior and attitude towards child:
   a. FATHER Positive / strengths Negative / weaknesses

   b. MOTHER Positive / strengths Negative / weaknesses

   c. SIBLINGS Name_____ Name_____
   Positive / strengths Positive / strengths

   Negative / weaknesses Negative / weaknesses

3. In your opinion, your child is most like which other family member? _____

School history

1. Did your child go to preschool? Yes_____ No _____
2. Were there problems encountered in preschool? Yes_____ No _____
3. Were there problems encountered in kindergarten? Yes_____ No _____
4. Does your child have difficulty getting along with his/her classmates? Yes_____ No _____
5. Has your child seen the school psychologist or other special education personnel? Yes_____ No _____
6. Has your child received special help at school? Yes_____ No _____
7. Are your child's current grades poorer than his/her apparent ability would suggest? Yes_____ No _____
8. Is your child's handwriting irregular and messy? Yes_____ No _____
9. Have teachers complained of over activity or disobedience? Yes_____ No _____
10. Have teachers complained about your child's inability to get along with others? Yes_____ No _____
11. Have teachers complained that your child attacks other children? Yes_____ No _____
12. Does your child seem unable to concentrate long on anything? Yes_____ No _____
13. Has your child ever refused to go to school? Yes_____ No _____
14. Does your child withdraw from group at school? Yes_____ No _____
15. Does your child complain that other children pick on him/her? Yes_____ No _____
16. Has your child ever been suspended from school? Yes_____ No _____
17. Do you feel it would be of some value to us to speak to school personnel? Yes_____ No _____
18. Where is your child currently going to school?
    _____
19. Special schools, instruction, or educational therapies and dates:
    _____
    _____
    _____

FAMILY QUESTIONNAIRE (cont.)

20. Intelligence and achievement tests (dates and results if known): _____
    _____
21. Areas of greatest ability: _____
22. Areas of greatest difficulty: _____
23. Attitudes towards school: _____
24. Attitudes towards teacher: _____
25. Attitudes towards other children: _____
26. Extracurricular interests and activities:_____
27. Attendance: ____ Attends regularly ____ Frequently absent ____Occasionally absent____ Never attends
    Tardy: ____ Usually ____Sometimes ____ Rarely
28. Summarize your contact with school personnel during the past year: _____
    _____

General Behaviors

1.	Does your child currently have problems sleeping?	Yes_____ No _____
2.	Do other children make fun of your child?	Yes_____ No _____
3.	Has your child ever rolled or banged his/her head rhythmically?	Yes_____ No _____
4.	Does your child find it difficult to make friends?	Yes_____ No _____
	Has he/she had these difficulties before?	Yes_____ No _____
5.	Does your child play alone a great deal?	Yes_____ No _____
6.	Is your child shut out from other children's play?	Yes_____ No _____
	Has this occurred before?	Yes_____ No _____
7.	Does your child annoy or antagonize other children?	Yes_____ No _____
8.	Does your child seem to daydream quite a bit?	Yes_____ No _____
9.	Has your child ever seemed unusually withdrawn?	Yes_____ No _____
10.	Has your child ever engaged in any strange or bizarre behavior?	Yes_____ No _____
11.	Is your child either left handed or ambidextrous?	Yes_____ No _____
12.	Does your child cry easily?	Yes_____ No _____
	Has he/she done so in the past?	Yes_____ No _____
13.	Is your child unduly upset by criticism?	Yes_____ No _____
14.	Is your child currently impulsive in his/her behavior?	Yes_____ No _____
	Has there been a problem before?	Yes_____ No _____
15.	Does your child desire to be alone rather than with others?	Yes_____ No _____
16.	Does your child react out of proportion when faced with problems?	Yes_____ No _____
	Has he/she done so in the past?	Yes_____ No _____

FAMILY QUESTIONNAIRE (cont.)

17. Check any of the following that currently apply to your child:

____ Hearing Problems	____ Eye Problems	____ Irritability
____ Excessive Crying	____ Sleep Disturbances	____ Bed Wetting
____ Learning Difficulties	____ Daytime Wetting	____ Masturbation
____ Aggressiveness	____ Thumb Sucking	____ Anger
____ Unusual Fears	____ Can't Make Friends	____ Conflicts
____ Inferiority Feelings	____ Unable to Have a Good Time	____ Allergies
____ Eating Problems	____ Convulsions	____ Blank Spells
____ Cruelty to Animals	____ Coordination Problems	____ Fire Setting
____ Destructiveness	____ Temper Tantrums	____ Stealing
____ Restlessness	____ Bowel Soiling	____ Headaches
____ Suicidal Ideas	____ Can't Make Decisions	____ Feel Tense
____ Memory Problems	____ No appetite	____ Shy
____ Speech/Language Problems	____ Head Banging	____ Rocking
____ Difficulty Separating from Parents	____Strange Behavior/Thinking	____ Nightmares
____ Poor Attention Span	____ Palpitations	____ Depressed
____ Nervous Habits/Tics	____ Feel Panicky	____ Fighting
____ Sexual Problems	____ Fainting Spells	____ Take drugs

18. What does your child enjoy doing the most? _____
19. What makes your child angry? _____
20. What do you like about your child? _____
21. What do you dislike about your child? _____
22. What activities most interest your child? (Underscore those he/she likes)_____
    _____
23. How long can your child work or play at one activity?_____
24. How do you discipline your child? (Indicate who usually does it)_____
    _____

FAMILY QUESTIONNAIRE (cont.)

25. Has your child ever been separated from the family for a prolonged period of time? ____ Yes ____ No
26. How many times has your family moved since this child was born? _____

Your reason for seeking help

1. What are the behaviors from Section F (General Behaviors) above that you are most concerned about and want assistance with? _____
   _____
2. Did a specific event lead to requesting assistance at this time? ____ Yes ____ No
   If yes, when? Explain: _____
   _____
3. Is the child currently involved with legal authorities? ____ Yes ____ No
   If yes, who? Explain: _____
   _____
4. Date of anticipated court hearings: _____

Please draw a diagram of your home including where every member sleeps.