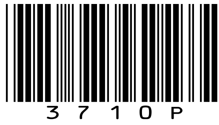
Lurie Children's Primary Care
Town & Country Pediatrics
Family Background Questionnaire



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Date/Time: ________________ Person Completing Form: ________________________________
Relationship to Patient: ________________________________

Interpreter (as applicable) ____

Clinician Comments

Identifying Information

Child's Name: ____

Date of Birth: ________________ **Age:** ________________ **Gender:** ☐ Male ☐ Female

Ethnicity/Race

☐ White ☐ African-American ☐ Hispanic ☐ Asian
☐ Other ____

Is there anything about your cultural background that is important for the clinician to know? ____

____

Child's Mental Health History

Has the child ever had an evaluation or treatment for behavior or emotional problems?

☐ No *(If no, go to child's development history)*
☐ Yes *(If yes, please list where it was provided, most recent place first)*

#1 Place of service or name of clinician:____

Service setting: ☐ Outpatient, approximate number of sessions ______________________
☐ Inpatient ☐ Partial/day program ☐ Residential

Diagnosis (if known): ____

Dates of service: ________________ to ________________

Type of service *(mark all that apply)*

☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication
☐ Group therapy

If medication was used, please list all medications, doses, start and stop dates, and reason for stopping:

____

____

#2 Place of service or name of clinician:____

Service setting: ☐ Outpatient, approximate number of sessions ______________________
☐ Inpatient ☐ Partial/day program ☐ Residential

Diagnosis (if known): ____

Dates of service: ________________ to ________________

Type of service *(mark all that apply)*

☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication
☐ Group therapy

If medication was used, please list all medications, doses, start and stop dates, and reason for stopping:

____

____

Clinician Comments

#3 Place of service or name of clinician:____________________

Service setting: ☐ Outpatient, approximate number of sessions __________
☐ Inpatient ☐ Partial/day program ☐ Residential

Diagnosis (if known): ____________________

Dates of service: ________ to ________

Type of service *(mark all that apply)*

☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication
☐ Group therapy

If medication was used, please list all medications, doses, start and stop dates, and reason for stopping:

____

____

#4 Place of service or name of clinician:____________________

Service setting: ☐ Outpatient, approximate number of sessions __________
☐ Inpatient ☐ Partial/day program ☐ Residential

Diagnosis (if known): ____________________

Dates of service: ________ to ________

Type of service *(mark all that apply)*

☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication
☐ Group therapy

If medication was used, please list all medications, doses, start and stop dates, and reason for stopping:

____

____

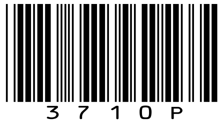
Child's Development History

Did the child's birth mother have any of the following problems during her pregnancy with the child? *(Mark all that apply. If marked, please explain)*

☐ Excessive vomiting __________
☐ Anemia __________
☐ High or low blood sugar __________
☐ Infection __________
☐ Bleeding __________
☐ Injury to abdomen __________
☐ Stress or emotional problems __________
☐ Use of prescribed medication __________
☐ Use of over-the-counter medication __________
☐ Use of cigarettes, alcohol, or drugs __________
☐ X-rays to abdomen __________
☐ Other __________
☐ Don't know __________

Did the child's birth mother have any of the following problems during her labor/delivery of the child? *(Mark all that apply. If marked, please explain)*

☐ Premature delivery __________
☐ Long labor __________
☐ Breech or forceps delivery __________
☐ Caesarian delivery __________
☐ Infection at delivery __________
☐ Medication during delivery __________



Clinician Comments

- ☐ "Blue baby"/lack of oxygen at birth ____________
- ☐ Yellow jaundice at birth ____________
- ☐ Birth injury or defects ____________
- ☐ Intensive care after birth ____________
- ☐ Other ____________
- ☐ Don't know ____________

What was the child's birth weight? ________ pounds ________ ounces

At what approximate age did the child reach his/her developmental milestones?

Walked ____________ months
Said first words ____________ months
Said phrases ____________ months
Said sentences ____________ months
Toilet trained ____________ months

Temperament

☐ Easy	☐ Average/typical	☐ Irregular	☐ Sensory sensitivities
☐ Rigid	☐ Slow to warm up	☐ Over-active	☐ Uncertain
☐ Stubborn	☐ Negative mood	☐ Distractible	
☐ Avoidant	☐ Intense reactions	☐ Impulsive	

Typical Discipline? ____________

Child's Medical History

Pediatrician or family physician: ____________
Address: ____________
Phone Number: ____________

Are the child's immunizations up-to-date? ☐ No ☐ Yes

Has the child had any of the following medical problems? *(Mark all that apply. If marked, please explain)*

- ☐ Allergies ____________
- ☐ Head injury ____________
- ☐ Loss of consciousness ____________
- ☐ Brain infection ____________
- ☐ Seizures ____________
- ☐ Dizzy/fainting spells ____________
- ☐ Headaches ____________
- ☐ Trouble seeing ____________
- ☐ Trouble hearing ____________
- ☐ High or low blood sugar ____________
- ☐ Excessive screen time (TV, Computer, Videogames) ____________
- ☐ Thyroid problems ____________
- ☐ Stomach/ intestine problems ____________
- ☐ Liver problems ____________
- ☐ Kidney problems ____________
- ☐ Heart problems ____________
- ☐ Lung problems/asthma ____________
- ☐ Anemia ____________
- ☐ High lead level ____________
- ☐ Lack of exercise ____________
- ☐ Frequent or long-lasting pain ____________
- ☐ Other ____________

Clinician Comments

Does the child take any medicine every day (other than vitamins)?
☐ No ☐ Yes, ______________________________

Has the child been in the hospital for an illness, injury, or surgery?
☐ No ☐ Yes When __________ Reason __________________
When __________ Reason __________________
When __________ Reason __________________

When was the child's last complete physical examination?
Date: __________ Results: ☐ Normal ☐ Abnormal
If abnormal, please describe: ______________________________

Nutrition

Given the child's height, would you say he/she is:
☐ Underweight ☐ Just right ☐ Overweight

Has the child recently experienced:
Weight loss ☐ No ☐ Yes
Weight gain ☐ No ☐ Yes

Do you have any concern about the child's eating habits or preferences?
☐ No ☐ Yes

Sleep

How many hours a night does the child usually sleep? __________________
Does the child still nap regularly? ☐ No ☐ Yes – If yes, how many hours? __________
Does the child have any sleep problems? ______________________________

Medical Problems for Close Blood Relatives

Has the child's biological father, biological mother, or biological brothers/sisters had any of the following medical problems? *(Mark all that apply. If marked, indicate which relative.)*

☐ Heart disease __________________
☐ Sudden death __________________
☐ Seizures __________________
☐ Headaches __________________
☐ Diabetes __________________
☐ Thyroid problems __________________
☐ Tics __________________
☐ Other __________________
☐ Don't know __________________

Psychiatric Problems for Close Blood Relatives

Has the child's biological father, biological mother, or biological brothers/sisters had any of the following psychiatric problems? *(Mark all that apply. If marked, indicate which relative.)*
☐ None ☐ Unknown

Psychiatric problems:
☐ ADHD __________________
☐ Depression __________________

- ☐ Bipolar ______________________
- ☐ Anxiety ______________________
- ☐ Schizophrenia ______________________
- ☐ Suicide ______________________
- ☐ Autism ______________________
- ☐ Substance abuse ______________________
- ☐ Tourette's ______________________
- ☐ Other ______________________

Learning/language problems:

- ☐ Mental retardation ______________________
- ☐ Learning disability ______________________
- ☐ Language impairment ______________________

Personality problems:

- ☐ Explosive ______________________
- ☐ Irritable ______________________
- ☐ Aggressive ______________________
- ☐ Unpredictable ______________________
- ☐ Moody ______________________
- ☐ Rigid ______________________
- ☐ Isolative ______________________
- ☐ Other ______________________

Behavior problems:

- ☐ Substance Use ______________________
- ☐ Criminality ______________________
- ☐ Abusive ______________________
- ☐ Other ______________________

Clinician Comments

Social History

Please indicate if any of the following events have occurred in your family within the last 6 months and/or in your child's lifetime

	Last 6 months	Over 6 months
Family member or close friend died	☐	☐
Family member or close friend had serious illness or injury	☐	☐
Parents had marital or relationship problems	☐	☐
Parents separate or divorced	☐	☐
Parents engaged in custody dispute	☐	☐
Family had financial problems	☐	☐
Family had housing problems	☐	☐
Family relocated	☐	☐
Child changed schools	☐	☐
Child was removed from custody of birth parent	☐	☐
If foster child, foster placement changed	☐	☐
Child had lengthy separation from primary caregiver	☐	☐
Child witnessed domestic dispute	☐	☐
Child witnessed neighborhood violence	☐	☐
Child was a crime victim	☐	☐
Child was physically abused	☐	☐
Child was sexually abused	☐	☐
Child was neglected	☐	☐
Family was involved with DCFS	☐	☐
Birth of a sibling	☐	☐
Gun present in home	☐	☐

Clinician Comments

Family Composition

Household members *(Please list all adults and children living full-time or part-time in the home.)*

Relationship to child	*Name*	*Age*	*Occupation*	*Degree/highest grade completed*

Marital Status of current parents

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married
☐ Other ______________________________

Marital Status of biological parents *(if different)*

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married
☐ Other ______________________________

Who is the child's legal guardian? *(name and relationship to child)*

____

Religion

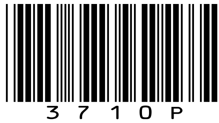
Is there anything about your faith/spirituality that is important for the clinician to know?

☐ No ☐ Yes, please describe ______________________________

Does your family practice a specific faith or religion?

☐ No ☐ Yes, please describe ______________________________

____



Clinician Comments

Learning Style

How does the parent/caregiver prefer to learn?

☐ Written materials ☐ Explanation ☐ Demonstration ☐ Audio/Visual
☐ Other ____________________

How does the child prefer to learn?

☐ Written materials ☐ Explanation ☐ Demonstration ☐ Audio/Visual
☐ Other ____________________

Child's School History

School currently attending ____________________

☐ Public ☐ Parochial ☐ Private ☐ Home

How many schools has the child attended *(including preschool)*? ____________

Current grade

☐ Pre-K ☐ 7
☐ K ☐ 8
☐ 1 ☐ 9
☐ 2 ☐ 10
☐ 3 ☐ 11
☐ 4 ☐ 12
☐ 5 ☐ Too young for school
☐ 6 ☐ Other ____________

Has the child ever failed or been held back a grade?

☐ No ☐ Yes, which grade(s)? ____________
____
____

What are the child's usual grades? ____________________

Does (has) the child receive(d) special education services?

☐ No ☐ Yes, where ____________ when ____________

Results ____________________

Has the child ever been tested for learning or language problems?

☐ No ☐ Yes, where ____________ when ____________

	Good	*Average*	*Poor*
Attendance	☐	☐	☐
Behavior	☐	☐	☐
Friendships	☐	☐	☐
Reading ability	☐	☐	☐
Math ability	☐	☐	☐
Writing ability	☐	☐	☐
Homework completion	☐	☐	☐

Leisure Activities

Please describe the child's leisure and recreation activities *(sports, music, dance, art, computer, etc.)*

____

____

Signature of person completing form: ____________________

Date: ____________ **Time:** ____________

Signature of reviewing clinician: ____________________

Date: ____________ **Time:** ____________ **Pager/Phone:** ____________