meadowlark
PSYCHIATRIC SERVICES
1 South Gilbert Street, Iowa City, IA 52240
319.626.3300

HISTORY AND BACKGROUND QUESTIONNAIRE

We appreciate the opportunity to work with your family. The information you give us is important for our evaluation. Please note that some of the questions may not be applicable given your concerns. If that is the case, please write "NA" in that section.

PATIENT INFORMATION

Today's date: _____ Name of Person Completing this Form: _____

Patient's Full Name: _____ Birth Date: _____

Identified Gender: _____ Race/ethnicity/cultural identity: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Referred for evaluation by: _____

Do you have legal authority to bring this patient to this appointment? ☐ Yes ☐ No

FAMILY INFORMATION

Parent's Name: _____

Highest Level of Education Attained: _____

Parent listed here is:

☐ biological parent ☐ adoptive parent

☐ foster parent ☐ step parent

☐ other: _____

Place of Employment: _____

Occupation: _____

Work phone: _____

Cell phone: _____

E-mail: _____

Address, if different than child's: _____

_____

Parent's Name: _____

Highest Level of Education Attained: _____

Parent listed here is:

☐ biological parent ☐ adoptive parent

☐ foster parent ☐ step parent

☐ other: _____

Place of Employment: _____

Occupation: _____

Work phone: _____

Cell phone: _____

E-mail: _____

Address, if different than child's: _____

_____

Please list ALL individuals currently living in the child's home:

Name	Gender	Age	Relationship to Child

Please list ALL legal guardians of the child (if necessarily, please provide a copy of guardianship papers):

BACKGROUND

How old was your child when you first became concerned about their development? _____

What were your first concern(s)? _____

_____

_____

Who raised these concerns? _____

Describe your child's current difficulties and the age at which these difficulties started:

Current Difficulty *Age Started*

1. _____
2. _____
3. _____

Do you have any concerns regarding speech and/or language? ☐Yes ☐No

If yes, please describe: _____

_____

Is English the primary language spoken in the home? ☐Yes ☐No

Other languages spoken in the home and child's fluency: _____

Do you usually understand what your child says? ☐Yes ☐No

Do others usually understand what your child says? ☐Yes ☐No ☐N/A

Does your child understand most things said to them? ☐Yes ☐No

Any additional concerns? _____

_____

_____

What do you hope to gain from this evaluation? _____

_____

_____

_____

Are there any concerns or issues you do not want discussed in front of your child? _____

_____

_____

Please describe your child's strengths and interests: _____

_____

_____

What do you like to do with your child? _____

_____

_____

SCHOOL INFORMATION

Name of School: _____

School's Address: _____

Current Grade: _____

Has your child repeated any grade? ☐ Yes ☐ No If yes, what grade(s):_____

Have school problems ben reported? ☐Yes ☐No

If yes, what are they and when were they reported? _____

_____

Is your child teased/bullied? ☐Yes ☐No

Does your child currently have an ISFP, IEP, or 504 Plan? ☐Yes ☐No

If yes, we would like a copy. Please upload as an attachment or mail a hard copy.

Does your child receive any services at school? ☐Yes ☐No

If yes, please list: _____

_____

Describe your child's academic strengths/weaknesses: _____

_____

_____

_____

EVALUATION AND TREATMENT HISTORY

Does your child have any psychiatric or developmental diagnoses (e.g., ADHD, disruptive behavior disorder, anxiety disorder, specific learning disorder)? ☐Yes ☐No

If yes, please list: _____

_____

Has your child previously been evaluated by a psychologist, speech/language pathologist, OT, educational consultant, or other developmental specialist? ☐Yes ☐No

Please list evaluations, your child's age at time of evaluation, and outcome. *Also, please provide copies of these evaluations either by uploading as attachment or mailing a hard copy.* _____

_____

_____

Does your child receive any of the following therapy/treatment or have they in the past?

☐Psychiatric Care*:*

Provider	Current Medication	Dosage

☐Private Speech/Language Therapy (not school based)

Provider	How Often	Dates Attended	Focus

☐Private Behavior Therapy/Counseling/Psychotherapy (e.g., ABA, FCT, PCIT, BHIS, play therapy, social skills group, family therapy, CBT, Project ImPACT, play therapy, etc.)

Provider	How Often	Dates Attended	Focus

☐Private Occupational Therapy (e.g. sensory integration, handwriting, ADLs, fine motor):

Provider	How Often	Dates Attended	Focus

☐Private Physical Therapy

Provider	How Often	Dates Attended	Focus

MEDICAL AND DEVELOPMENTAL HISTORY

Was your child adopted? ☐Yes ☐No If yes, at what age: _____

Did your child's mother have any illnesses or problems with her pregnancy? Yes No

If yes, please describe: _____

During pregnancy, did your child's mother:

Smoke? ☐Yes ☐No
Drink alcohol? ☐Yes ☐No
Use drugs? ☐Yes ☐No
Use medication? ☐Yes ☐No

If yes to any of the above, what and when? _____

Child's birth weight? _____

Was your child born (check one):

☐Between 38-42 weeks ☐Before 38 weeks ☐After 42 weeks

Was the delivery ☐vaginal ☐cesarean If cesarean, why? _____

Did your child have any problems immediately after birth? ☐Yes ☐No

If yes, please describe: _____

Did your child go home with mother from the hospital? ☐Yes ☐No

If no, please explain: _____

Were there any difficulties during your child's first month at home? ☐Yes ☐No

If yes, please describe: _____

Describe your child in the first 6 months (e.g., cuddly, colicky, difficult to soothe, feeding problems, sensory aversions, etc.): _____

_____

Please indicate the age (in months or years) at which the child first demonstrated the following:

Smiled at caregiver:	_____	Understood single words:	_____
Waved 'bye bye":	_____	Said 1st word:	_____
Sat by self:	_____	Put two words together:	_____
Crawled:	_____	Spoke in sentences:	_____
Walked by self:	_____	Toilet trained (daytime):	_____
Babbled:	_____	Dry through night:	_____

Do you consider your child to be in good health? ☐Yes ☐No

If no, please explain: _____

_____

Does your child have any medical concerns? ☐Yes ☐No

If yes, please explain: _____

_____

Has your child had any surgical procedures/operations: ☐Yes ☐No

If yes, please list procedure and dates: _____

_____

_____

List current medications, including over-the-counter and herbal: _____

_____

_____

FAMILY HISTORY

Is your child's family currently having significant stress? ☐Yes ☐No

If yes, what is stressful: _____

_____

Does your child have relatives (e.g., parents, brothers, sisters, grandparents, aunts, uncles, first cousins) with the following:

	Who? (Please indicate mother's or father's side of family)
Seizures	_____
Neurological disease	_____
Diabetes	_____
Thyroid problems	_____
Hearing problems	_____
Anxiety	_____
Attention-deficit/hyperactivity disorder	_____
Autism spectrum disorder	_____
Bipolar disorder	_____
Depression	_____
Intellectual disability	_____
Learning problems	_____
Obsessive compulsive disorder	_____
Psychosis/Schizophrenia	_____
Speech/language problems	_____
Tics	_____
Alcohol abuse	_____
Drug abuse	_____
Problems with the law	_____
Suicide/attempted suicide	_____
Other: _____	_____
Other: _____	_____

Is there anything that was not asked on this form that you feel would be important for us to know?

Please return completed form to:

meadowlark
PSYCHIATRIC SERVICES

GeneralMailbox@MeadowlarkPsych.Com

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Fax: 319.626.3084