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**Date** \_\_\_\_\_ **Child's Name** \_\_\_\_\_  
Mo. Day Yr. (last) (first) (middle)

*Biographical Information - Child*

**INSTRUCTIONS TO PARENTS: To assist in helping your child, please fill out this form as frankly as you can, and return it to the above address. Please fill out the form to the best of your knowledge. If some questions are not applicable to your child, write in N.A. If you need more space or wish to make an additional comment, please attach a separate sheet. If possible, please enclose a recent photograph of your child. The facts on this form will be held in the strictest confidence and no one else will be permitted to see this form without your written permission. PLEASE PRINT YOUR ANSWERS.**

1. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Policy Holder's Soc Sec # \_\_\_ - \_\_\_ - \_\_\_
2. Address: \_\_\_\_\_  
Street City State Zip
3. Home Phone: \_\_\_\_\_ Business Phone: (mother) \_\_\_\_\_ (father) \_\_\_\_\_
4. Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_ (pager/cell #) \_\_\_\_\_
5. Business Address (Father/Mother): \_\_\_\_\_
6. Father's Occupation: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_
7. Pediatrician: \_\_\_\_\_  
Address: \_\_\_\_\_  
and  
Telephone \_\_\_\_\_
8. School Currently Attending: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address: \_\_\_\_\_  
and  
Telephone \_\_\_\_\_
9. Reason for Consultation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Who referred you?  self  school or teacher  family doctor  social agency  hospital or clinic  friend  relative  
 attorney  other (explain) \_\_\_\_\_  
Has this party been here?  Yes  No
11. Name of Person Filling Out This Form: \_\_\_\_\_ Relationship to Child \_\_\_\_\_

**MEDICAL HISTORY**

12. Please list and give dates for all illnesses or periods of hospitalization and indicate if there were changes in child's personality or alertness after the illness. *Was the child ever knocked out or was there ever a loss of consciousness?*

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13. Did the child ever have a high fever?  Yes  No If yes, describe circumstances (Temp, age, illness name - measles, mumps, etc.)

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14. Did the child ever have convulsions or lose consciousness?  Yes  No If yes, describe circumstances

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**FAMILY HISTORY**

15. Birthplace Birth Date Education Occupation Handedness (L/R)

Mother \_\_\_\_\_

Father \_\_\_\_\_

Other Children/Household Members

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16. Has anyone in the family (or extended family) ever had a serious physical illness or mental ailment?  Yes  No

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17. Who in the family has had difficulty in school, and what was the difficulty? \_\_\_\_\_

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**DEVELOPMENTAL HISTORY**

18. Was there any difficulty in developing eating habits (inability to adjust to formula, gagging, swallowing, etc.)?  Yes  No

Foods especially disliked or not tolerated: \_\_\_\_\_

**DEVELOPMENTAL HISTORY** <sup>Con't</sup>

At what age did child sit up? \_\_\_\_\_

At what age did child say first word? \_\_\_\_\_

At what age did child crawl? \_\_\_\_\_

What was it? \_\_\_\_\_

At what age did child stand up? \_\_\_\_\_

Begin to talk in sentences? \_\_\_\_\_

At what age did child begin to walk? \_\_\_\_\_

Begin to drink from a glass? \_\_\_\_\_

At what age *FULLY* toilet trained? \_\_\_\_\_

When did toilet training begin? \_\_\_\_\_

Does child still have toilet accidents? \_\_\_\_\_ If yes, how often and when? \_\_\_\_\_

19. Did child go to nursery school?  Yes  No If yes, at what age and how did s/he respond? \_\_\_\_\_

20. **Has your child ever manifested any of the following?**

	<u>YES</u>	<u>At What Age?</u>	<u>How long did it last?</u>
Head banging.....	<input type="checkbox"/>	_____	_____
Thumb sucking.....	<input type="checkbox"/>	_____	_____
Nail biting.....	<input type="checkbox"/>	_____	_____
Nightmares.....	<input type="checkbox"/>	_____	_____
Sleepwalking.....	<input type="checkbox"/>	_____	_____
Temper tantrums.....	<input type="checkbox"/>	_____	_____
Unusual tics or twitches. <input type="checkbox"/>		_____	_____

21. How did the child adjust to kindergarten? (include adjustment to children and teacher). \_\_\_\_\_

22. How does child get along with his brothers and sisters? \_\_\_\_\_

23. How many friends does s/he have? (Give ages and sex) \_\_\_\_\_

24. What kinds of things does s/he do with his friends? (Give examples) \_\_\_\_\_

25. How does s/he occupy himself when s/he is alone? \_\_\_\_\_

26. What does s/he like to do best? \_\_\_\_\_
27. How responsible is s/he with respect to *dressing, bathing, taking care of his personal effects*? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
28. Is s/he helpful around the house? (give examples) \_\_\_\_\_
- \_\_\_\_\_
29. What experience has s/he had with money? \_\_\_\_\_
30. How far can s/he travel on his own? \_\_\_\_\_
31. Can s/he ride a bicycle?  Yes  No \_\_\_\_\_ Can s/he swim?  Yes  No \_\_\_\_\_
32. What is his attitude towards school and how does s/he behave there? \_\_\_\_\_
- \_\_\_\_\_
33. In what way is s/he most difficult to manage? \_\_\_\_\_
- \_\_\_\_\_
34. Who punishes him when s/he misbehaves and how does s/he respond to it? \_\_\_\_\_
- \_\_\_\_\_
35. Whom does s/he resemble most in *personality*, his mother or father, *and in what way*? \_\_\_\_\_
- \_\_\_\_\_
36. How much sex education has s/he received? \_\_\_\_\_
37. What was the source of this information? \_\_\_\_\_ At what age did s/he receive it? \_\_\_\_\_

***INSURANCE INFORMATION***

38. Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_
39. Insured Name \_\_\_\_\_ ID # \_\_\_\_\_
40. ***Additional Comments*** \_\_\_\_\_
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- \_\_\_\_\_
- \_\_\_\_\_