



## PARENT QUESTIONNAIRE

Dear Parent,

Please fill out this form as best you can. Having all the facts will help us do the most thorough evaluation and be most helpful to you. If you can't remember something exactly, put an approximate answer with a question mark. Please feel free to use the backs of the pages for extended answers.

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Mothers name: \_\_\_\_\_ Mothers Occupation: \_\_\_\_\_

Fathers name: \_\_\_\_\_ Fathers Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Work telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

email: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Relation to child: \_\_\_\_\_

Who else did you consult while completing this form?: \_\_\_\_\_

Relation to the child?: \_\_\_\_\_

Who were you referred by?: \_\_\_\_\_

Is your child adopted? \_\_\_\_\_

Right or Left-handed?: \_\_\_\_\_

If your child is left-handed are there other family members who are left-handed?:

\_\_\_\_\_

Hair color: \_\_\_\_\_ Eye color: \_\_\_\_\_

Date of last vision test & results: \_\_\_\_\_

Date of last hearing test & results: \_\_\_\_\_

1. What specific questions do you hope to have answered by this evaluation/consultation and/or treatment (e.g., learning issues, giftedness, social, and/or emotional issues)?

2. Do you have any concerns about your child? (If No, skip to question 6 below)

3. What do you think may be causing the difficulties you are concerned about?

4. What interventions have you tried in the past to help with these areas of difficulty? (e.g., tutoring, counseling, speech therapy, occupational therapy, behavior management programs, etc.)

5. What do you consider to be this child's greatest:

A. Strengths:

B. Challenges:

6. Has this child already had testing/evaluations/an IEP? If yes, what were the results and conclusions? (Please include copies of reports and IEPs.)

7. What other information do you think is important for us to know about your child?

**8. PRENATAL HISTORY:**

How was your general health during the pregnancy? \_\_\_\_\_

How was did you feel emotionally during your pregnancy? \_\_\_\_\_

Any particular life stressors during the pregnancy? \_\_\_\_\_

How much weight did you gain during the pregnancy? \_\_\_\_\_lbs.

How active was the baby? \_\_\_\_\_

Check (✓) which of the following conditions occurred, if any, and then elaborate:

( ) Edema (swelling of feet) \_\_\_\_\_

( ) High blood pressure \_\_\_\_\_

( ) Fever/Infections \_\_\_\_\_

( ) Vaginal bleeding \_\_\_\_\_

( ) Hospitalizations \_\_\_\_\_

( ) X-rays/medical procedures \_\_\_\_\_

( ) Trauma accidents \_\_\_\_\_

( ) Exposure to environmental toxins (e.g., paint, chemicals) \_\_\_\_\_

( ) Other (anemia, poor health, seizures, etc.) \_\_\_\_\_

List any medications (prescribed or over-the-counter) or injections you received during this pregnancy:

Medication	Reason	Amount Taken	During what months?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check (✓) any that apply and describe frequency & quantity used & during what months:

( ) Cigarettes \_\_\_\_\_

( ) Alcohol \_\_\_\_\_

( ) Drugs (e.g., cocaine, speed, heroin, marijuana, LSD, etc.) \_\_\_\_\_

How was your nutrition during the pregnancy? \_\_\_\_\_

Did you get regular exercise? How often, how much? \_\_\_\_\_

**9. BIRTH HISTORY:**

Birth weight: \_\_\_\_lbs. \_\_\_\_oz. Length: \_\_\_\_\_ Apgar Scores: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ # of days baby in hospital: \_\_\_\_\_

Type of birth: ( ) vaginal ( ) c-section

Presentation: ( ) head ( ) breech

Type of anesthesia: ( ) gas ( ) spinal ( ) caudal block

Was your baby: ( ) on time ( ) early ( ) late By how many days/weeks: \_\_\_\_\_

Number of hours in labor: \_\_\_\_\_

Please check (✓) and EXPLAIN below:

Was there anything wrong with the baby before delivery? ( ) yes ( ) no

If yes, describe: \_\_\_\_\_

- After delivery, was there any difficulty with:
- ( ) breathing
  - ( ) cord around neck
  - ( ) jaundice
  - ( ) poor suck/feeding
  - ( ) other: \_\_\_\_\_

Did the baby receive special treatments for any problems? ( ) yes ( ) no

If yes, please check and explain further:

- ( ) bilirubin lights \_\_\_\_\_
- ( ) IV's (fluids, medicines, etc.) \_\_\_\_\_
- ( ) evaluation in an intensive care nursery \_\_\_\_\_
- ( ) oxygen or respirator \_\_\_\_\_
- ( ) special feedings \_\_\_\_\_
- ( ) other \_\_\_\_\_

What was the birth like for you? \_\_\_\_\_

What was the birth like for your partner? \_\_\_\_\_

How did you feel during the first few days after the birth? \_\_\_\_\_

How did your partner feel/respond during the first few days after the birth? \_\_\_\_\_

How were things in the home environment during the early weeks and days of the baby's life?

\_\_\_\_\_

**10. DEVELOPMENTAL HISTORY:**

Please check (✓) which milestones this child has achieved or can now do. Give the child's approximate age in weeks or months when s/he first could do them. If the child is unable to do a particular activity write N/A. If you cannot remember or do not know when the child was first able to do an activity write D/K. You may find that a baby book, dated photos, and association with various events in your life may help you remember these things.

- ( ) Roll from front to back and back to front \_\_\_\_\_
- ( ) Sit unsupported \_\_\_\_\_
- ( ) Creep or crawl on hands and knees \_\_\_\_\_
- ( ) Walk alone unsupported \_\_\_\_\_
- ( ) Walk up stairs, alternating feet \_\_\_\_\_ Walk downstairs, alternating feet \_\_\_\_\_
- ( ) Pedal a tricycle \_\_\_\_\_ ( ) Pedal a bicycle \_\_\_\_\_
- ( ) Reach out for a nearby object \_\_\_\_\_ ( ) Throw a ball \_\_\_\_\_
- ( ) Feed self with fingers \_\_\_\_\_ ( ) Feed self with spoon \_\_\_\_\_
- ( ) Drink from a cup without help \_\_\_\_\_
- ( ) Undress self \_\_\_\_\_ Dress self \_\_\_\_\_ Tie shoes \_\_\_\_\_
- ( ) Toilet trained \_\_\_\_\_

Describe your toilet training methods & how this period went: \_\_\_\_\_

- ( ) Babble with sound like "baba/mama" \_\_\_\_\_
- ( ) Point to specific objects \_\_\_\_\_ ( ) Point to body parts \_\_\_\_\_
- ( ) Understand "no," or "stop it" \_\_\_\_\_
- ( ) Say a word with meaning (not just mama/dada) \_\_\_\_\_
- ( ) Follow a simple command \_\_\_\_\_
- ( ) Put two or more words together in a simple phrase \_\_\_\_\_
- ( ) Name a color correctly \_\_\_\_\_
- ( ) Speech is clear to both family members and strangers \_\_\_\_\_

**As a baby, was your child (circle as many as apply):** intense, interested in her/his surroundings, friendly with strangers, affectionate, attached to an object, overactive, independent, more interested in people, more interested in objects, a self-starter, other:

How would you describe your child's personality?

As an infant? \_\_\_\_\_

As a toddler? \_\_\_\_\_

As a 3-5 year-old? \_\_\_\_\_

As a 6 year-old? \_\_\_\_\_

7-8 year-old? \_\_\_\_\_

8-10 years? \_\_\_\_\_

10-12 years? \_\_\_\_\_

12-14 years? \_\_\_\_\_

14-18 years? \_\_\_\_\_

Any history of:	Age Began	Check if Still
Head banging	_____	_____
Stuttering	_____	_____
Breath holding	_____	_____
Day soiling	_____	_____
Temper tantrums	_____	_____
Nail biting	_____	_____
Excessive Jealousy	_____	_____
Hitting	_____	_____
Frequent crying	_____	_____
Irritability	_____	_____
Excessive thumb sucking	_____	_____
Excessive masturbation	_____	_____
Hurting self	_____	_____
Sleep problems	_____	_____
Nightmares	_____	_____
Bedwetting	_____	_____
Excessive fears	_____	_____
Excessive fantasizing	_____	_____
Intentionally hurting others	_____	_____
Problems going to school	_____	_____
Problems making friends	_____	_____

**11. CHILD HEALTH HISTORY:**

**Please check all of the following which this child has had and explain as necessary in the open space following each item:**

- ( ) Hospitalizations \_\_\_\_\_
- ( ) Surgery \_\_\_\_\_
- ( ) Trauma (lacerations, fractures, serious accidents, etc.) \_\_\_\_\_
- ( ) Head injury \_\_\_\_\_
- Loss of consciousness: ( ) yes ( ) no \_\_\_\_\_
- ( ) Seizures/convulsions/fits \_\_\_\_\_
- ( ) Meningitis \_\_\_\_\_
- ( ) Other serious illnesses/infections/high fevers \_\_\_\_\_
- ( ) Asthma/allergies \_\_\_\_\_
- ( ) Ear infections How many? \_\_\_\_\_
- ( ) Hearing problems \_\_\_\_\_
- ( ) Vision problems \_\_\_\_\_
- ( ) Sleep problems (including nightmares, sleepwalking, bedwetting, etc.) \_\_\_\_\_
- ( ) Toileting problems \_\_\_\_\_
- ( ) Temper tantrums/aggressive behavior \_\_\_\_\_
- ( ) Crying spells \_\_\_\_\_
- ( ) Unusual behaviors (e.g., rocking, flapping, picking at self, etc.) \_\_\_\_\_
- ( ) Other problems, describe: \_\_\_\_\_
- \_\_\_\_\_
- ( ) Medications (specify type and for treatment of what condition) \_\_\_\_\_
- \_\_\_\_\_

Do you have any concerns about this child's eating habits, diet, nutrition, or growth?

- ( ) yes ( ) no If yes please describe: \_\_\_\_\_
- \_\_\_\_\_

**12. FAMILY HISTORY:**

Please describe all pregnancies of this child's mother: List each time a pregnancy occurred and the type (e.g., full term, premature, stillborn, miscarriage, etc.) Describe pertinent health issues of each child.

Year of birth:	Type:	Male/Female:	Health Issues
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

**Information regarding biological parents:**

Age now:	Health Issues:	If deceased, age/cause:
Mother: _____	_____	_____
Father: _____	_____	_____

Please check all of the following which any immediate biological relatives of the child (e.g., father/mother, grandparents, brother/sister, aunt/uncle, cousin) may have had, and explain as necessary in the space next to each item:

- ( ) Inherited/genetic conditions \_\_\_\_\_
- ( ) Birth defects \_\_\_\_\_
- ( ) Cerebral palsy/neuromuscular disorders \_\_\_\_\_
- ( ) Slow or delayed development \_\_\_\_\_
- ( ) Learning disabilities/dyslexia \_\_\_\_\_
- ( ) Hyperactivity/attention deficit disorder (ADD, ADHD) \_\_\_\_\_
- ( ) Hearing/visual problems \_\_\_\_\_
- ( ) Thyroid or other hormone disorder \_\_\_\_\_
- ( ) Cancer \_\_\_\_\_
- ( ) Alcoholism or drug abuse \_\_\_\_\_
- ( ) Emotional problems/nervous breakdown \_\_\_\_\_
- ( ) Schizophrenia \_\_\_\_\_
- ( ) Manic Depression/Bipolar Illness \_\_\_\_\_
- ( ) Depression \_\_\_\_\_
- ( ) Anxiety \_\_\_\_\_
- ( ) Autism/ Asperger's \_\_\_\_\_
- ( ) Gifted \_\_\_\_\_

### **13. SOCIAL HISTORY:**

Please list who lives in the home with this child:

How long did the child sleep in the parents' bedroom?

Does the child now or in the past share a room or bed with someone else? With whom? At what age?

Describe history of day care and list who currently cares for this child throughout the day:

Briefly describe school history. What schools has the child attended? Has the child repeated or skipped any grades? In what academic areas has the child done well or done poorly? Describe involvement in extra-curricular school activities, such as sports, clubs, etc.

Briefly describe the child's socialization history. How well does s/he relate to other children who are the same age? Has this pattern changed over time? How well does s/he relate to adults and older children? Does this child have many friends? A few friends? Very few friends? Does s/he frequently get into arguments or fights with peers?

Please describe guardians who primarily raised this child:

Name:	# of years in school:	Occupation:	Marital Status:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please describe siblings:

Name:	Age:	School Grade:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

How would you characterize your child's relationship(s) with his/her siblings?

What is your child's relationship like with you?

What discipline methods have you found to be most effective with your child?

What are your child's favorite activities?

What are your child's least favorite activities?

In what after-school activities does s/he participate?

Please list any chores or jobs your child has at home (e.g., paper route, babysitting, making her/his bed, etc):

How well does your child carry out the above chores?

Has your child ever been in counseling or therapy? Please describe any previous counseling—reasons for treatment, length of treatment, therapist name, type of treatment (e.g., family, individual, group therapy).

Any other relevant information about the family, such as information about divorce, remarriage, parental death, death of other important family figures, etc.:

Is there anything else you wish to add that has not been covered by this questionnaire?