SUMMIT CENTER

Reach New Heights

Assessments • Consultation • Counseling

PARENT QUESTIONNAIRE

Dear parent or guardian,
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.

Date Completed:_____

Child's Name:_____ Birthdate: _____ Age: _____

Gender: _____ Pronoun _____ Biological sex assigned at birth: ◯ Female ◯ Male

Grade: _____ School: _____

Ethnicity: _____ Primary language: _____

Other languages spoken:_____

Child's Handedness (Please circle) ◯ Left ◯ Right ◯ Ambidextrous

1) Parent/Guardian: _____ Occupation: _____

Cell phone: _____ Work telephone: _____

Email: _____ Home telephone: _____

2) Parent/Guardian: _____ Occupation: _____

Cell phone: _____ Work telephone: _____

Email: _____ Home telephone: _____

Home Address: _____

City:_____ State: _____ Zip Code: _____

Name of person completing form: _____

Relation to the child: _____

Who else did you consult while completing this form?: _____

Relation to the child?_____

Who were you referred by?: _____

www.summitcenter.us
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310.478.6505, Ext. 0

Child's Height: _____ Weight: _____ Hair color: _____ Eye color: _____

Does the child wear glasses (If so, since what age?): _____

Date of last vision test & results: _____

Who conducted the evaluation (please circle and name)? ◯ School ◯ Pediatrician ◯ Optometrist

Name: _____ ◯ Developmental Optometrist

Has the client been identified as a candidate for vision therapy? If so, note by what professional, whether the child has proceeded with vision therapy, for how long, when, and with who.

_____

_____

Date of last hearing test & results: _____

Who conducted the evaluation? _____

Does the child wear hearing aids (If so, since what age?): _____

Has the client been evaluated by an Audiologist? If so, note by what professional, whether the child has proceeded with an auditory processing intervention, for how long, when, and with who.

_____

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

_____

_____

Describe any recent medical, academic, or other events that led to this assessment.

_____

_____

What are your concerns about your child? What do you think may be causing the difficulties you are concerned about?

_____

_____

_____

What interventions have you tried in the past to help with these areas of difficulty? (circle and explain)

☐ Tutoring ☐ Counseling ☐ Speech Therapy ☐ Occupational Therapy ☐ Vision Therapy

☐ Auditory Processing Intervention ☐ Reading & Writing Program ☐ Behavior Management Program

_____

_____

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

A. Strengths: _____

B. Challenges: _____

Has the child already been given any diagnoses? ☐ Yes ☐ No

If yes, what are they? _____

By whom, and when? _____

Does the child's sibling(s) have a diagnosis? ☐ Yes ☐ No

If yes, what is it/are they? _____

Does the child's parent(s) have a past or current diagnosis? ☐ Yes ☐ No

If yes, what is it/are they? _____

Has this child already had testing/evaluations/504 Plan/IEP? If yes, what were the results and conclusions? (Please include copies of relevant reports and IEPs.) _____

_____

Forms to be completed by child's teacher should be emailed to:
Teacher's Name _____ Teacher's Email Address: _____

BACKGROUND HISTORICAL INFORMATION

Pregnancy

Information relevant to conception (Elaborate as needed) _____

_____

How was mother's health during the pregnancy? _____

_____

Were there any prenatal or perinatal complications, or complications in childbirth? _____

_____

☐ Mother smoked while pregnant (if yes, _____ packs/day)

☐ Mother drank alcohol while pregnant (if yes, amount _____)

☐ Mother took drugs while pregnant (e.g. cocaine, speed, heroin, marijuana, etc.)

☐ Mother took medications (prescribed/ over the counter) while pregnant? If yes, what? _____

If yes to medications, what months were these taken? _____

☐ RH incompatibility between mother and baby

☐ Mother had an accident/ injury

☐ Mother was anemic

☐ Mother had diabetes

☐ Mother had high blood pressure

☐ Mother had illnesses/ infections

☐ Mother had preeclampsia, eclampsia, or toxemia

☐ Mother had spotting or bleeding

☐ Mother had surgery

☐ Mother had vomiting (severe or frequent)

☐ Mother experienced severe emotional stress and/or psychological problems during pregnancy

☐ Episodes of false labor

☐ Baby had unusual level of activity within the womb: ◯ more ◯ less active than other pregnancies

☐ How often did mother see her doctor during the pregnancy (circle one)?

◯ Regularly (as scheduled by the doctor) ◯ Rarely ◯ Not at all

☐ Other _____

Childbirth

Where was the baby born (hospital/city)? _____

Length of pregnancy (in weeks) _____

Length of labor (hours) _____ Was labor induced? ◯ Yes ◯ No

Birth was: ☐ Normal/vaginal ☐ Breech ☐ Cesarean ☐ Twins/multiple births ☐ Other _____

How was labor for the mother (circle one)? ☐ Easy ☐ Moderately difficult ☐ Very difficult

What were the child's APGAR scores? _____

Which of the following were used to assist in delivery?

☐ Epidural ☐ Other anesthesia ☐ Forceps ☐ Vacuum

Did the baby need any medical help starting to breathe/ fail to cry/ or appear inactive? _____

Describe any other complications in the birth _____

Birth weight: ___lbs. ___oz. Length: _____ Was the baby in the NICU? ◯ Yes ◯ No

If so, for how long? _____

Did the baby have any difficulty with any of the following during the first month of life?

☐ Evaluation in the intensive care nursery?

☐ Jaundice - Did the baby receive bilirubin lights?

☐ Cyanosis ("blue baby")

☐ Excessive crying

☐ Seizures

☐ Failure to thrive

☐ Feeding problems

☐ Did the baby receive any medications? If so, which ones? _____

☐ Did the mother have any other postpartum complications? _____

☐ Did the baby have to stay in the hospital for an extended time? ☐ Yes ☐ No

☐ Other _____

MEDICAL HISTORY

Pediatrician's name and phone number: _____

When was your child's last visit with the pediatrician? _____

Please check all of the following which this child has had and explain in the open space following:

☐ Hospitalizations _____

☐ Surgery _____

☐ Trauma (lacerations, fractures, serious accidents, injuries, etc.) _____

☐ Head injury _____

☐ Loss of Consciousness _____

☐ Seizures/convulsions/fits _____

☐ Meningitis _____

☐ Serious illnesses/infections/high fevers _____

☐ Asthma _____

☐ Allergies (any food/medication allergies) _____

☐ Ear infections: How many/ when? What was treatment? _____

☐ Hearing problems _____

☐ Vision problems _____

☐ Sleep problems (including nightmares, sleepwalking, bedwetting, etc.) _____

☐ Other problems or medical diagnoses: _____

☐ Medications (Please list all current medications. Specify type, dosage and for treatment of what condition)

_____

Past Medications: _____

Do you have any concerns about this child's eating habits, diet, nutrition, or growth? ☐ yes ☐ no

If yes please describe: _____

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).

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

Briefly, what was the child like to care for as an infant? _____

_____

Did the child achieve motor milestones on time? ☐ Yes ☐ No

At what age did he/she start crawling? _____ months. First walk? _____ months

Do you have any concerns about the child's strength and coordination? ☐ Yes ☐ No

If yes, please describe. _____

Did the child achieve language milestones on time? ☐ Yes ☐ No

At what age did the child say his/her first words? _____ months

What was the child's first word? _____

At what age did the child say his/her first sentence _____ months

Does the child speak clearly? ☐ Yes ☐ No If no, what sounds are hard to say? _____

Does the child have trouble picking up on nonverbal cues such as gestures or humor? ☐ Yes ☐ No

Please describe any other concerns you have about your child's language development. _____

_____

How old was the child when he/she learned to: Dress/undress self? _____

Tie shoes? _____ Use the toilet: Bladder-trained? _____ Bowel trained? _____

Describe any concerns about the child's self-help skills. _____

Is the child a picky eater? ☐ Yes ☐ No Does the child follow any special diet? ☐ Yes ☐ No

If so, please describe: _____

_____

Personality and Temperament

How would you describe your child's personality? (e.g., intense, interested in her/his surroundings, friendly with strangers, affectionate, attached, overactive, independent, more interested in people, more interested in objects, a self-starter, sensitive, shy, etc.):

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? _____

Does your child have a history of any of these issues? If so, please indicate the date the problem began, if they are still a problem, and whether/what type of interventions you have tried.

☐ Head banging _____

☐ Stuttering _____

☐ Breath holding _____

☐ Toileting problems _____

☐ Temper tantrums _____

☐ Nail biting _____

☐ Excessive jealousy _____

☐ Hitting _____

☐ Frequent crying _____

☐ Irritability _____

☐ Frequent thumb sucking _____

☐ Hurting self _____

☐ Bed wetting _____

☐ Excessive fears _____

☐ Excessive fantasizing _____

☐ Intentionally hurting others _____

☐ Problems going to school _____

☐ Problems making friends _____

☐ Unusual behaviors (e.g., rocking, flapping, picking at self, etc.) _____

☐ Changes in weight or appetite _____

☐ Changes in mood _____

☐ Changes in energy level _____

Does your child get regular exercise? _____

If so, how often? What type? _____

Sleep related issues:

How many hours per night does your child sleep? _____

Does your child have any of the following (please circle). If so, please explain.

☐ Insomnia ☐ Nightmares ☐ Frequent waking during the night

☐ Night terrors ☐ Sleepwalk

_____

Does child have a CPAP machine or other sleep related treatment? If so, please explain.

_____

FAMILY/SOCIAL HISTORY

Was the child adopted? ☐ Yes ☐ No If yes, from where? _____ Foster child? _____

Are the child's parents ☐ married ☐ divorced since _____ ☐ separated since _____
☐ single ☐ other _____

If the parents are not together, what is the custody agreement? _____

_____

Contact information to reach the non-custodial parent (if needed):

_____

Indicate specifically which parent(s) holds the legal right to authorize and consent to the child's treatment by a mental health practitioner.

_____

Indicate which parent(s) have been given rights to access information about the child's treatment and/or evaluation.

_____

If applicable, please include a copy of documentation pertaining to custody and rights to consent to treatment by a mental health practitioner. Please check here if a copy has already been provided. ☐

Information regarding biological parents:

Bio Mother Name _____ Age _____ Occupation _____

Bio Father Name _____ Age _____ Occupation _____

Please indicate any health problems of the bio parents. If deceased, please indicate age/cause of death.

_____

What is the child's first language? _____ Any other languages spoken at home? _____

Please list who lives in the home with this child (parents, siblings (age/grade), grandparents, etc.):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

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

_____

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

_____

_____

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

_____

_____

What is your child's relationship like with you? What do you appreciate most about your child?

_____

_____

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

_____

_____

Does your child have any special talent/ abilities? _____

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 your child prefer: ☐ Group activities ☐ Individual activities ☐ Either

_____

Does the child have (circle all that apply):

☐ Same age friends ☐ Friend of mixed ages ☐ Older friends ☐ Younger friends

☐ A large group of friends ☐ A few close friends ☐ 1 or 2 good friends ☐ Plays alone

Does s/he frequently get into arguments or fights with peers?

_____

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 at the bottom:

- ☐ Inherited/genetic condition
- ☐ 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
- ☐ Other _____

_____

_____

Any other relevant information about the family (i.e. information about divorce, remarriage, parental death, death of other important family figures, etc.) or significant life stressors (i.e. moving, change of school, etc.) that you would like me to know about? _____

_____

_____

EDUCATIONAL HISTORY

Describe your child's school history. What schools has your child attended?

School	**For Which Grades?**	**Type of School (Public/Private)**

Is there a family history of early educational difficulty (like trouble learning to read)? _____

Did your child receive any early intervention services? If so, which ones? When? _____

_____

Has the child repeated or skipped any grades? If so, which ones? _____

_____

In what academic areas has the child done well or done poorly? _____

_____

_____

Please list recent grades/subject areas: _____

_____

Does your child receive any special services at school (Please circle and explain)?

- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Resource Room Access
- ☐ Placement in a special classroom
- ☐ Gifted Program
- ☐ Physical Therapy
- ☐ Counseling
- ☐ Pull-out tutoring
- ☐ Placement in a special school
- ☐ Other

_____

_____

What are your child's favorite activities? _____

_____

What are your child's least favorite activities? _____

_____

Does your child enjoy going to school? If not, why? _____

_____

Does your child get along with his/her teachers and peers? _____

_____

Describe involvement in extracurricular school activities, such as sports, clubs, etc.

_____

_____

_____

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

_____

_____

_____

_____