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Parent Questionnaire

Child's Name________________________ Date of Birth____________ Age_________ Grade_______

Name of Person Completing Form_________________________ Relationship to Child_____________

Address____

Home Phone_________________ Work Phone________________ Cell Phone__________________

Email____________________________________ Referred by_________________________________

Child's Pediatrician____

Reason for Referral____

____

Your child's strengths____

Your child's weaknesses____

Please give information about other professionals who have been involved with your child, including psychotherapists, speech/language therapists, occupational therapists, neurologists, etc.

Name of Professional	Address	Dates

PREGNANCY, BIRTH AND DELIVERY

Did the birth mother have any problems during the pregnancy?_________________________________

How many weeks was the pregnancy?________________ Any illness with fever and/or rash?_______

Drug or Alcohol use?__________ Birth Weight___________ Apgar Scores_____ 1min.______5 min.

Complications during birth? (Breech, Csection, prolonged labor, loss of oxygen)__________________

____

Any other difficulties during labor and/or delivery?____________________________________

Age of mother at delivery:________________ Age of father at delivery________________________

Age at discharge?_______ Was there any trouble during the first week of life?___________________

____

If Jaundice, did the baby require phototherapy___________ or exchange transfusions______________

How was the first month?____

DEVELOPMENTAL MILESTONES

Age when crawled__________ Age when walked without holding on_________________

Was your child slow to develop gross motor skills or awkward compared to siblings and/or friends? If so, which ones—running, skipping, biking, etc.____

Hand preference___________

Age when said first words__________ 2-3 words together____________

Speech problems (stuttering, difficulty being understood)___________________________________

Was there a point in time when he/she lost language? If so, when?______________________________

Has speech therapy been provided?____

Toileting: Age trained for: urine___________ bowels_________________

Are/were there bedwetting problems?_____________________ At what age controlled?___________

Are/were there soiling problems?____

Did your child experience?

Drooling past age 2 ½	☐Yes ☐ No
Difficulty sucking as an infant	☐Yes ☐ No
Difficulty chewing	☐Yes ☐ No

MEDICAL HISTORY

Has your child had any serious illness?

Illness	When	For how long?
		_____Mos. _____Yrs.
		_____Mos. _____Yrs.
		_____Mos. _____Yrs.

		_____Mos. _____Yrs.

Has your child been hospitalized?

What for?	When	For how long?
		_____Mos. _____Yrs.
		_____Mos. _____Yrs.
		_____Mos. _____Yrs.
		_____Mos. _____Yrs.

Has your child had any operations?

What?	When

Has your child had seizures/convulsions? ☐ Yes ☐ No If yes, at what age? ______________________

Were the seizures associated with a high fever? ☐ Yes ☐ No

Has your child been treated for seizures? ☐ Yes ☐ No With what medication(s)?____________________

Has your child ever had: ☐ Meningitis or encephalitis

☐ Any other neurological illness ___________________________

☐ Lead poisoning or toxicity

Does your child have asthma or allergies? ☐ Yes ☐ No Describe: _________________________________

Has your child had any head injuries? ☐ Yes ☐ No

What happened?____

When did it happen?______________ Was there loss of consciousness?_______________________

For how long?___________________ Was he/she hospitalized? _____________________________

Has your child had loss of consciousness not associated with head injury? _________________________

How often does your child have abdominal pains/vomiting?_____________________________________

When does this occur?____

Does your child have headaches? ☐ Yes ☐ No How often? ___________ How treated?___________

Does your child have any difficulties related to eating? ☐ Yes ☐ No

Does your child have any difficulties related to sleeping? ☐ Yes ☐ No

Has hearing been checked? ☐ Yes ☐ No When? ___________ Any problems?___________________

Has vision been checked? ☐ Yes ☐ No When? ___________ Any problems?___________________

Does your child have a history of frequent ear infections? ☐ Yes ☐ No

How often? __________ When? ___________ Treatment? _______________________________

List any medications your child currently takes: ____

____

BEHAVIOR

Does your child get along well with: Other children__________ Brothers/sisters__________________

Does he/she have friends?_______________________ Can he/she keep friends?__________________

Does he/she get along well with adults?____________

Does your child have difficulty staying at one activity for a reasonable length of time? ☐ Yes ☐ No

Does your child have trouble reading social cues (know when others are angry/upset, understanding

humor? ? ☐ Yes ☐ No ____

FAMILY HISTORY

Please list all siblings, include stepparents.

Relation	Name	Age	Education	Occupation	Health	School/Behavior Problems
Mother						
Father						

Language spoken at home ____

Did anyone in the extended family—including aunts, uncles, and first cousins—have:

Neurological Disease	☐Yes ☐ No		Emotional/Behavior Problems	☐Yes ☐ No
Slowness in Walking	☐Yes ☐ No		Problems with Drugs or Alcohol	☐Yes ☐ No
Seizures	☐Yes ☐ No		Mental Retardation	☐Yes ☐ No
Hearing Problems	☐Yes ☐ No		Learning Problems	☐Yes ☐ No
Slowness in Talking	☐Yes ☐ No		Similar Problems to your child	☐Yes ☐ No
Visual Problems	☐Yes ☐ No		Left-handedness	☐Yes ☐ No
Hyperactivity	☐Yes ☐ No		Autistic Spectrum Disorder	☐Yes ☐ No
Other	☐Yes ☐ No			

CURRENT FAMILY SITUATION

Which family member(s) does he/she spend the most time?____

Which family member does he/she get along best with?____

Are there significant conflicts between your child and his parents?__________________________________

Do the parents agree on how to discipline? ____

Who disciplines and how? ____

How does he/she respond to discipline?____

Are the child's problems frequently the source of parental arguments? _______________________________

Are there significant marital conflicts? ____

SCHOOL HISTORY

Did he/she attend nursery school? ☐ Yes ☐ No Age started______________

Did he/she attend kindergarten? ☐ Yes ☐ No Any problems in kindergarten?___________________

Current School: ____

Address:____

Phone:____________________ Principal:_______________________ Teacher(s)______________________

Other school personnel involved:____

Present Grade___________ Grades repeated, if any________________________________

Has the school reported problems with:

Reading?	☐ Yes	☐ No	Writing?	☐ Yes	☐ No
Spelling?	☐ Yes	☐ No	Behavior?	☐ Yes	☐ No
Attention/Concentration?	☐ Yes	☐ No	Math?	☐ Yes	☐ No
Social adjustment?	☐ Yes	☐ No			

In what grade did school problems become noticeable?_______________

Has he/she had a previous psychological evaluation? ☐ Yes ☐ No

When?_______________ By Whom?______________________

Does your child now, or has he/she in the past received special education services? ☐ Yes ☐ No

For what subjects?____

What services have been provided?

Service		Hours/week
Resource Room	☐ Yes ☐ No	
Self-Contained Classroom	☐ Yes ☐ No	
Adaptive PE	☐ Yes ☐ No	
Speech/Language Therapy	☐ Yes ☐ No	
Occupational Therapy	☐ Yes ☐ No	
Physical Therapy	☐ Yes ☐ No	
Counseling/Psychotherapy	☐ Yes ☐ No	

Schools Attended	City	Grade(s)

Additional Notes:____