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PARENT QUESTIONNAIRE
INSTRUCTIONS

1.) Complete this questionnaire **before** your first appointment. (Do not separate questionnaire.)

2.) Please have your physician complete the last page of this questionnaire.

3.) Mark items "N/A" that are not applicable to you or your child.

4.) Please bring in any **report cards, prior evaluations and records** that you believe will help us understand your child.

5.) Please have your child's teacher complete the Teacher's Report Form and bring the completed form to the initial appointment.

1. Date: ____________________

Person completing form: ____
Relationship to Patient: ____

a. CHILD'S name: _____________________ Birthdate: _________Age: _______

b. MOTHER'S name: ____________________Birthdate: ____________________

Occupation: ____

Address: ____

Home Phone: __________________Currently Employed: Y/N

Mother's cell phone: ______________ Father's cell phone ________________

Work Phone: ____

c. FATHER'S name: ____________________Birthdate: ____________________

Occupation: ____

Address: ____

Home Phone: __________________Currently Employed: Y/N

Work Phone: ____

d. STEPMOTHER'S name and occupation (if applicable):
____
____

STEPFATHER'S name and occupation (if applicable):
____
____

2a. Who referred you to this practice?

2b. Please identify reasons you are seeking treatment.

2c. What have you said to your child about this evaluation?

2d. Whose idea was it to have this evaluation?

2e. When did the problem begin?

2f. How have you tried to deal with the problem to date?

List your child's strengths and weaknesses.

Strengths	Weaknesses

DO NOT WRITE ON THIS PAGE

PLEASE LIST THE NAMES OF ALL FAMILY MEMBERS WITH WHOM THE CHILD LIVES:

NAME	AGE	RELATION TO CHILD

PLEASE LIST ANY PARENTS OR SIBLINGS LIVING OUTSIDE OF THE HOME:

NAME	AGE	RELATION TO CHILD

FAMILY/ENVIRONMENTAL FACTORS

Are the biological/adoptive parents divorced? ______separated? _______widowed? ___________

If so, at what age was the child when these events occurred?
____
____

If biological/adoptive parents are divorced, who has legal custody? _________________________
____

Does the child visit the non-custodial parent? ____________ If so, how often? _______________
____

Who cared for the child during the first two years? Describe changes in caretakers:
____

Was English the child's first language? __________ IF not, what was the first language and when did the child learn to speak English? ____

Did the child attend daycare? ____________ If so, at what ages? __________________________

Did the child attend preschool? ___________If so, at what ages? __________________________

Were both parents involved in the child's care? ____

Who stays with the child when the child is ill? ____

What forms of discipline do you use? ____

Who usually disciplines the child? ____

Do both parents usually agree on discipline? Y/N If no, please elaborate: __________________

Are there differences in parenting style? Y/N If yes, please elaborate: ____________________

How is affection shown? ____

Do you have extended family in the area to help with the child? Y/N
Describe: ____

Does the child have a close relationship with an adult not presently living at home? (e.g., grandparent, relative, family friend) If so, who? ____________________________________

What other support systems do you have? ____

Where do you turn for suggestions and information regarding parenting and child development? ____

Is **father** employed outside the home? Y/N

If so, where? ________________________________ How many hours per week? ____________

Is **mother** employed outside the home? Y/N

If so, where? ________________________________ How many hours per week? ____________

Mother's educational level: ____

Father's educational level: ____

Who watches your child after school hours? ____

Does the child play outside in the neighborhood? ____

What activities does your child enjoy? ____

What family activities do you enjoy? ____

What stressors are you and your family currently experiencing? ____

What kinds of jobs or household responsibilities does your child have? ____

Does he/she do them willingly? ________________ Without prompting? __________________

Has your child ever had a psychological or psychiatric evaluation? _____________________________

If so, when and by whom? ____

Has your child ever been hospitalized for emotional reasons? _____________________________

Has your child had any prior therapy, psychological or psychiatric treatment? ________________

Describe your child's and your response to treatment. What did you like/not like about treatment? ____

The following is a checklist of twelve characteristics or conditions that may run in families. We are interested in whether anyone in the family other than this child has had any of these. Please put an X in the column of the family member(s) who have or have had each characteristic or condition. If more than one brother or sister has or has had one of these characteristics or conditions, put an X for each one in the appropriate column (e.g., if there were two bothers who had trouble learning how to read, you would put two X's next to item 2 under the column "Child's Brother(s)"). The "Others" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	Child's Mother	Child's Father	Child's Brother	Child's Sister	Others (Specify)
Hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Speech problems					
Behavior problems in childhood					
In trouble as a teenager					
Kept back in school					
An honor student					
Mental retardation					
Depression, mania or Bipolar Disorder					
Drug or alcohol problems					

DO NOT WRITE ON THIS PAGE

The following checklists help us to decide whether there are any medical factors that might be important. The checklist entitled "Possible Pregnancy Problems" concerns the pregnancy with this child, except for the last two items, which refer to previous pregnancies. The "Newborn Infant Problems" checklist is about the baby's first month of life. Please read each list; then put an X in the appropriate column following each item.

POSSIBLE PREGNANCY PROBLEMS	TRUE	NOT TRUE	NOT SURE
Had bleeding during first 3 months			
Had bleeding during second 3 months			
Had bleeding during last 3 months			
Gained 30 or more pounds Specify: ______ lbs.			
Had toxemia			
Had to take medications*			
Vomited often			
Got hurt or injured			
Gained less than 15 pounds Specify: ______ lbs.			
Took narcotic drugs			
Drank much alcohol			
Had an infection			
Smoked one (or more) packs of cigarettes per day			
Labor lasted longer than 12 hours Specify: ______ hours			
Labor lasted less than two hours			
Had a cesarean section			
Had a difficult delivery			
Was put to sleep for delivery			
Had previous miscarriages			
Had previous premature baby(ies)			

Length of this pregnancy: _________ months

*Specify any medications: ____

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Other pregnancy problems/illnesses: ____

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NEWBORN INFANT PROBLEMS	TRUE	NOT TRUE	NOT SURE
Born with cord around neck			
Injured during birth			
Had trouble breathing			
Turned yellow (jaundice)			
Turned blue (cyanosis)			
Was a twin or triplet			
Had an infection			
Was given medications			
Had seizures (fits, convulsions)			
Had diarrhea			
Needed oxygen			
Was in hospital more than 7 days			
Gagged often			
Vomited often			
Born with heart defect			
Born with other defect(s)			
Had trouble sucking			
Had skin problems			
Was very jittery			

Baby's birth weight ________ lbs. _________ oz.

Please list any other problems

1. ____
2. ____
3. ____

Describe your child's temperament as an infant and toddler: ________________________________

____

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The checklist entitled "Health Problems" is about any medical problems the child may have had. The "Functional Problems" checklist includes personality or behavioral problems the child may had . In both lists, if the child has had any of these problems, please put an X in the first column and list the age(s) the problem occurred. These two checklists follow:

FUNCTIONAL CONDITIONS	X	AGE(S)
Feeding difficulty or eating problem		
Poor appetite		
Unwillingness to try new foods		
Very unpredictable appetite		
Overeating		
Colic		
Constipation		
Abdominal pains		
Trouble falling asleep		
Very unpredictable length of sleep		
Very heavy sleeping		
Overactivity		
Head banging		
Rocking in bed		
Temper tantrums		
Self-destructive behavior		
Difficulty in being comforted or consoled		
Stiffness or rigidity		
Looseness or floppiness		
Crying often and easily		
Shyness with strangers		
Bashfulness with new acquaintances		
Irritability		
Extreme reaction to noise or sudden movement		
Difficulty in keeping to a schedule		
Trouble getting satisfied		
Desire to be held too often		
Failure to be affectionate toward parents		
Unwillingness to go along with change in daily routine		
Tendency to make odd sounds, grunts, or snorts		

Was child breast-fed? _______ If so, until age ____.

HEALTH PROBLEMS	X	AGE(S)
Ear infection(s)		
Rashes or skin problems		
Meningitis		
Seizures (convulsions) or spells		
High fevers (over 103)		
Pneumonia		
Asthma		
Slow weight gain		
Trouble with ears or hearing		
Trouble with eyes or vision		
Diarrhea		
Hospitalization(s)		
Surgery (operations)		
Serious injury(ies)		
Food allergies		
Other allergies		
Anemia (low blood count)		
Lead poisoning		
Other poisoning or overdose		
Heart problems		
Kidney or urinary problems		
Got sick after a shot (Immunization)		

Other important illness (specify):
a.

b.

Medications used over long period (specify)
a.

b.

The following is a checklist of early accomplishments of children. Please put the age at which this milestone first occurred in the column "AGE" next to the item. If there are items the child still cannot do, please mark these items with "NOT YET" in the "AGE" column. If they were within normal limits please write: WNL.

EARLY DEVELOPMENT	X	AGE
Sat up without help		
Crawled		
Walked alone (10-15 steps)		
Walked up stairs		
Rode a tricycle		
Caught a big ball		
Spoke first words (Mama, Dada, etc.)		
Put words together (Daddy bye-bye, etc.)		
Spoke 2-3 word sentences		
Spoke clearly so strangers understood		
Used fingers to feed self		
Used a spoon		
Fully bowel trained		
Fully bladder trained		
Able to separate easily from mother		

School: ____

Special education services? Y/N If yes, what type? ______________________

____

____

Grade: __________ Teacher: ______________________________

How does your child get along with this and other teachers they have had? __________

____

____

Overall grades: ____

____

Attendance: ____

Areas of difficulty: ____

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Social skills: ____

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Special programming or classes (Please include copies of ARD or 504 modifications): _________

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Likes or dislikes about school: ____

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____

DO NOT WRITE IN THE SPACE BELOW.

EARLY EDUCATIONAL EXPERIENCE	Did well	Had some problems	Had serious problems	Can't say
Behavior in nursery school/preschool				
Learning to read in 1st and 2nd grade				
Reading level in 3rd to 6th grade				
Learning to write the alphabet				
Behavior in 1st and 2nd grade				
Behavior in 3rd and 4th grade				
Behavior in 5th and 6th grade				
Learning arithmetic in 1st, 2nd & 3rd grade				
Learning arithmetic in 4th, 5th & 6th grade				
Learning to spell in 1st, 2nd & 3rd grade				
Good study habits				
Learning to spell in 4th, 5th & 6th grade				
Learning to tell time				
Learning days of week, months of year				
Learning to swim				
Learning to ride a bicycle				
Learning to catch and throw a ball				
Learning to follow rules				
Learning to obey adults				
Learning to get along with other children				
Staying out of trouble				
Learning to write words/sentences				
Learning to hold a pencil properly				
Learning to trace and draw				
Learning cursive writing				
Getting homework done in 4th, 5th & 6th grade				
Acquiring good study habits				
Learning to pay attention in school				

The following is list of behaviors and characteristics. All children show some of these at some time during their lives. To the right of each item, please put an X in the column which best describes this child during the past six months. If a particular item does not describe the child, put an X in the column "Not applicable or not sure."

KEY

Definitely applies = Is much more frequent and/or extreme than in others of the same age
Applies somewhat = Is sometimes more extreme than in others of the same age
Does not apply = Is usually appropriate or better than average for his or her age

	Definitely Applies	**Applies Somewhat**	**Does Not Apply**
ASSOCIATED BEHAVIORS			
Is moody			
Has a bad temper			
Is a worrier			
Has bad dreams			
Sleeps or tries to sleep with parents			
Is often sad			
Is often very quiet			
Whines often			
Is fearful of being alone			
Is fearful of new situations, people, places			
Is often tired			
Has stomach aches or headaches often			
Wets bed or pants often			
Soils underwear/has accidents with bowel movements			
Overeats often			
Bites nails or sucks thumb			
Often complains of pains in arms or legs			
Has nervous twitches or tics			
Complains of feeling ill often			
Has constipation			
Is often too concerned about cleanliness/neatness			
Tells lies			
Often takes things from parents/siblings without permission			
Starts fights with other children			
Bullies other children			
Is fresh, rude to grownups			
Destroys objects at home			
Is fearless			
Is mean			
Deliberately tries to make parents angry			

	Definitely Applies	Applies Somewhat	Does Not Apply
Gets in trouble with neighbors			
Is cruel to animals			
Is a “loner”			
Has no real friends			
Has mostly older friends			
Gets bossed by other children			
Clings to adults			
Gets picked on			
Demands to be the center of attention			
Is not liked by other children			
Is slow to make friends			

Below is a list of positive or good behaviors. Please indicate which of these pertain to your child by putting an X in the appropriate column to the right of each item.

	Definitely Applies	**Applies Somewhat**	**Does Not Apply**
ASSOCIATED STRENGTHS			
Has an even disposition, is easy to live with			
Usually seems happy			
Enjoys new experiences			
Easily becomes involved in many activities			
Takes pleasure in many activities			
Is affectionate			
Is kind or sympathetic if someone else is sad/hurt			
Is friendly and outgoing			
Plays well with other children			
Shares toys with others			
Accepts rules easily			
Plays gently with smaller children or animals			
Enjoys playing with other children			
Takes turns well			
Easily tolerates minor bumps and scratches			
Tolerates criticism well			
Handles frustrations well			
Is forgiving			
Stands up for himself/herself when necessary			
Recovers easily after disappointments			

COMPLETE FOR CHILD *NOT YET* IN ELEMENTARY SCHOOL

Note: Parents of older children may complete this as well, if their child had any of these behaviors as a toddler. In this section there is a list of sentences that parents use to describe their children. Please read each of these statements and place an X in the appropriate column.

KEY

Definitely applies = Is much more frequent and/or extreme than in others of the same age
Applies somewhat = Is sometimes more extreme than in others of the same age
Does not apply = Is usually appropriate or better than average for his or her age

	Definitely Applies	**Applies Somewhat**	**Does Not Apply**
ACTIVITY-ATTENTION PROBLEMS			
His/her body is in constant motion			
His/her body is underactive			
His/her mind seems overactive			
He/she has trouble sitting through a meal			
He/she does things without thinking			
He/she starts things, but doesn't finish them			
At times, he/she doesn't seem to hear what you say			
He/she does things in the wrong order			
He/she doesn't realize when he/she has made a mistake			
He/she has trouble falling asleep at night			
He/she has trouble staying asleep at night			
He/she yawns often during the day			
He/she breaks things around the home			
He/she seems to do things the hard way			
He/she stares at things for long periods			
He/she listens to outside noises for long periods			
He/she gets distracted easily			
He/she likes to keep changing games			
He/she is hard to control on a car trip			
He/she can't keep his/her hands to himself/herself			
He/she seems to want things all the time			

COMPLETE IF CHILD *IS IN* SCHOOL

The following checklist contains phrases and sentences that parents use to describe their children as they see them at home. All children act in these ways some of the time. Please read each item and put an X in the column that you think pertains to this student compared to most others of the same age. Use the key below.

KEY

Definitely applies = Is much more extreme than in others of the same age
Applies somewhat = Is a little more extreme than in others of the same age
Does not apply = Is not present or is present to a normal degree for this age

ACTIVITY-ATTENTION PROBLEMS	Definitely Applies	Does Not Apply	Applies Somewhat
Can concentrate for only a short time unless things are very interesting			
Misses important details of what he/she is being told			
Seems to “burn out” or fatigue easily when expected to concentrate			
Often seems lethargic or tired			
Doesn’t seem to plan or organize before doing things			
Is in a hurry to get work or chores over quickly instead of doing them carefully			
Has trouble memorizing things for school			
Learns a new skill or concept one day and then can’t seem to remember it a few days later			
Does the same job or task very well sometimes and extremely poorly at other times			
Receives very unpredictable (inconsistent) grades or test scores			
Often doesn’t notice when he/she makes mistakes			
Tends not to proofread or go back over his/her work			
Is a poor listener			
Seems to look around or stare a lot			
Says things that have little or no connection to what others are saying or what is going on			
Daydreams often; seems to be in his/her own world			
Is restless; gets bored easily			
Seems to want things or results right away and/or is hard to satisfy			
Thinks about friends or other students so much that he/she can’t work well			
Seems to disturb or annoy peers without realizing it			
Seems to have too much energy			
Is fidgety; has difficulty sitting still			
Moods are variable and hard to predict			
Gets into trouble without really meaning to			

Does this student have some special interests or abilities that might be important for what he or she will do as an adult?

_______ Yes _______ No _______ Possibly

Please list these interests or abilities.

Please add any information which you feel may help us better understand your child.

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Please attach a recent photograph of the child, if available, in the space below. This will help us remember him/her, if there is an inquiry from you after the evaluation. It is not essential, but it can be very useful. any size is acceptable.

ATTACH PHOTOGRAPH HERE

PHYSICIAN'S FORM - PLEASE DO **NOT** TEAR THIS PAGE OUT TO MAIL.
GIVE IT BACK TO THE PARENTS TO HAND CARRY. THANK YOU.

REASON FOR REFERRAL: ____
Height: _____ Percentile: _________ Weight: _____ Percentile: _________
Head Circumference: ____________ Percentile: _________
Blood Pressure: _____/______ General Appearance: ________________________________
Vision (Specify Test ___________________) ____________________________________
Hearing (specify Test __________________) ____________________________________

Place an X to the right of any abnormal findings. Cross out items not performed.

Hair and Scalp
Skin
Eyes-Fundoscopic
Eyes-Oculomotor
Eyes-Other
Ears-Tympanic Membranes
Ears-Canal
Ears-Other
Nasopharynx
Oropharynx
Mouth-Teeth, Gums
Mouth-Other
Neck-Palpation
Chest-Appearance
Lungs-Auscultation
Heart-Rhythm, Rate

Heart-Murmurs
Abdomen-Appearance
Abdomen-Masses
Genitalia-Hernia
Genitalia-Other
Anorectal
Lymph Nodes
Extremities-Joints
Extremities-Muscles
Extremities-Other
Vertebral Column
Cranial Nerves
Reflex Intensity
Reflex Symmetry
Pathological Reflexes
Gait

Sensation
Other Neurological
Urinalysis
Hemoglobin/hematocrit
Other Items, Tests:

Immunizations (Data Completed)
DT Polio
Measles Mumps
Rubella TB
Other(s)

Summary statement on findings and overall health: ______________________________
____
____
____
____

Describe abnormal findings: ____
____
____
____
____

Please attach any psychological, educational, psychiatric or relevant evaluations.
______ **PLEASE CHECK HERE IF YOU WOULD LIKE A COPY OF THE DIAGNOSTIC ASSESSMENT.**
Physician Name: ____
Address: ____
Phone Number: _________________________ **Fax Number:**____________________