Brian Zercher, Psy.D.
PRA Behavioral L.L.C.

PARENT QUESTIONNAIRE

Please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to, but please do the best you can.

PATIENT IDENTIFICATION

Child's Name: _____ Date of Birth: _____ Age: _____Sex: _____
PrimaryPhone #: _____ Parent Work#: _____
Grade: _____ School: _____ Birth Place: _____
Mother's Name: _____ Father's Name: _____
Step-parent's Name (if applicable): _____

REFERRAL SOURCE:
Referral Source:_____
Would you like us to have contact with any outside professionals? If yes, who? (Please note a release of Information will need to be completed and signed.) _____
_____

PURPOSE OF YOUR VISIT

MAIN PROBLEMS TO BE ADDRESSED (please give a brief summary)
_____
_____
_____
_____
_____
_____
_____

WHY DID YOU SEEK THE EVALUATION AT *THIS* TIME?
_____
_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHOLOGICAL HISTORY
(Please include contact with other professionals, medications, types of treatments, etc.)
_____
_____
_____
_____
_____

MEDICAL HISTORY

Current medical problems/medications *including allergies*:

_____

_____

Past medical problems/medications:

_____

_____

Other doctors/clinics where regularly seen:

_____

Any history of head trauma, seizures, seizure-like activity, "spaciness", or confusion?: (Please describe):

_____

_____

Any history of surgery?:

_____

Any history of accidents resulting in broken bones, lacerations, severe bruises?:

_____

Medical Hospitalizations (Place, cause, date, and outcome):

_____

_____

_____

Present Height: _____ Present Weight: _____ Date of last physical exam: _____

FAMILY AND FAMILY HISTORY

FAMILY COMPOSITION

Siblings (names, ages, biological relationship, closeness, conflicts)

_____

_____

_____

_____

_____

Family Development (Please list marriages, divorces, deaths, traumatic events, losses)

_____

_____

_____

Current Marital Satisfaction_____

Extended Family and Close Family Friends (contact frequency, influence, recent loss)

_____
_____
_____
_____

FAMILY STRESSES

(Please list current factors that are a source of stress in the family including financial concerns, marital difficulties, illness, job changes, moves, deaths of pets, etc)

_____
_____
_____
_____

FAMILY HISTORY

Natural Mother's History:

Age_____ Highest level of education: _____ Outside work (if applicable)_____
Learning problems (Specify) _____
Behavior problems (Specify) _____
Marriages: _____
Medical Problems: _____
Childhood Atmosphere (family position, important family details) _____
_____
_____
Has the mother ever sought counseling or psychiatric treatment? Yes _____ No_____
If yes, for what purpose? _____
_____
Please list any of the mother's blood relatives with learning problems, or mental health problems including Depression, anxiety, suicide attempts, hospitalizations, alcohol/drugs, psychosis: _____
_____

Naturall Father's History:

Age_____ Highest level of education: _____ Outside work (if applicable)_____
Learning problems (Specify) _____
Behavior problems (Specify) _____
Marriages: _____
Medical Problems: _____
Childhood Atmosphere (family position, important family details) _____
_____
_____
Has the father ever sought counseling or psychiatric treatment? Yes _____ No_____
If yes, for what purpose? _____
_____
Please list any of the father's blood relatives with learning problems, or mental health problems including Depression, anxiety, suicide attempts, hospitalizations, alcohol/drugs, psychosis: _____
_____

BIRTH AND DEVELOPMENT HISTORY

Birth Details

_____Adopted? Relevant details_____
_____

_____IVF/Donor? Relevant Details_____
_____

Prenatal events

Circumstances of pregnancy(planned?, ease of conception, parent attitudes re:pregnancy):_____
_____

Pregnancy complications (bleeding, excess vomiting, medication, infection, x-rays, smoking,_____
_____

Drugs/alcohol/tobacco): _____

Birth and Postnatal Period

Birth weight _____ Length _____ Labor duration _____ Delivery: vaginal ____ C-section____
APGARS: _____ History of jaundice? Yes ___ No___ Time in hospital _____
Any other complications: _____
Mother's health after delivery: __ _____

Feeding History

Breast versus bottle _____ Food Allergies _____ Eating Difficulties? Yes ___ No___

Sleep Behavior (sleep walking, nightmares, recurrent dreams) _____
_____

Separations (from mother and/or father, age, duration and reaction)_____
_____

DEVELOPMENT

Motor Development (estimates of sitting, creeping, crawling, standing, walking ages and anything with fine or gross motor skills)_____
_____

Language Development (age babbling, when understanding what you say, first words, 3-word sentences, etc)_____
_____

Toilet Training

Age reached bowel control: Day ____ Night ____ Age reached bladder control: Day _____ Night ____
Current Function _____

Behavior/Discipline (in the patient's first 3 years of life):

Any specific unusual or problematic behavior _____
_____
_____

Emotional Development

Early temperament: _____
_____

Current personality: _____
Mood: _____
Habits: _____
Fears/Phobias: _____
Ability to express feelings: _____

Circle the following to describe the patient's temperament in the first two years of life:

Activity Level	Very Inactive	Inactive	Average	Active	Very active
Sensitivity to change in touch, sound level, lighting	Very Insensitive	Insensitive	Average	Sensitive	Sensitive
Adaptability to schedule changes	Very Unadapable	Unadaptable	Average	Adaptable	Very Adaptable
Ability to be calmed/soothed when distressed	Very difficult to Calm/Soothe	Difficult to Calm/Soothe	Average	Easy to Calm/Soothe	Very Easy to Calm/Soothe
Regularity in Sleep, eating	Very Irregular	Irregular	Average	Regular	Very Regular
Separating from parents	Very Difficult	Difficult	Average	Easy	Very Easy
Affection	Very Unaffectionate	Unaffectionate	Average	Affectionate	Very Affectionate

Social Development (please write age, parentheses are approximate normal limits)
Smile (2 months) _____ Shy with strangers (6-10 months) _____ Separates easily (2-3 years) _____
Cooperative Play (4 years) _____ Imaginative Play _____
Quality of attachment to mother _____
Quality of attachment to father _____
Relationship to family members _____
Early peer relationships _____
Current peer relationships _____
Hobbies/Interest _____

Sexual Development
Gender identity concerns _____

Physical/Sexual/Emotional abuse (please list any history of abuse)
_____

Drug/Alcohol History (please list any use that you are aware of or suspicious of, what kinds of drugs, how much, what age, how often)
_____
_____

School History
Current grade (pre-12th) _____ Average grades _____ Number of schools attended _____
Homework problems _____
History of identified learning disabilities, special education services, or education assistance done outside the school environment?_____
_____
_____
Specific concerns regarding learning _____
_____
History of attendance problems_____
Strengths _____
Motivation _____

History of having been bullied_____
History of suspensions, expulsions, retention _____

Does your child currently receive treatments for any neurological or psychological conditions? (For medications, include doses and times of day meds are taken)_____

_____

_____

_____

_____

Is there anything else important for the therapist to know? Any recent changes in your child's life?_____

_____

_____

_____

Overall Strengths

_____

_____

_____

_____

_____

_____ _____

Name of Parent Completing form Date