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## 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: \_\_\_\_\_  
Primary Phone #: \_\_\_\_\_ 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)

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#### WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

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#### PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHOLOGICAL HISTORY

(Please include contact with other professionals, medications, types of treatments, etc.)

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**MEDICAL HISTORY**

Current medical problems/medications *including allergies*:

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Past medical problems/medications:

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Other doctors/clinics where regularly seen:

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

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Any history of surgery?:

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

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

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**Present Height:** \_\_\_\_\_ **Present Weight:** \_\_\_\_\_ **Date of last physical exam:** \_\_\_\_\_

**FAMILY AND FAMILY HISTORY**

**FAMILY COMPOSITION**

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

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

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**Current Marital Satisfaction**

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

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**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)

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**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) \_\_\_\_\_

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Has the mother ever sought counseling or psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what purpose? \_\_\_\_\_

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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: \_\_\_\_\_

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**Natural 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) \_\_\_\_\_

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Has the father ever sought counseling or psychiatric treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what purpose? \_\_\_\_\_

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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: \_\_\_\_\_

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<b>BIRTH AND DEVELOPMENT HISTORY</b>
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**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:**

<b>Activity Level</b>	Very Inactive	Inactive	Average	Active	Very active
<b>Sensitivity to change in touch, sound level, lighting</b>	Very Insensitive	Insensitive	Average	Sensitive	Sensitive
<b>Adaptability to schedule changes</b>	Very Unadaptable	Unadaptable	Average	Adaptable	Very Adaptable
<b>Ability to be calmed/soothed when distressed</b>	Very difficult to Calm/Soothe	Difficult to Calm/Soothe	Average	Easy to Calm/Soothe	Very Easy to Calm/Soothe
<b>Regularity in Sleep, eating</b>	Very Irregular	Irregular	Average	Regular	Very Regular
<b>Separating from parents</b>	Very Difficult	Difficult	Average	Easy	Very Easy
<b>Affection</b>	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-12<sup>th</sup>) \_\_\_\_\_ 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