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PARENT QUESTIONNAIRE

Providing the following information will help me better understand this child. All information will be kept confidential. Write additional comments, as needed. Thank you for your time and effort in completing this.

Child's Name:	Birth date: / /	Age:
	Gender: □ M □ F	Grade:
Your Name:	Relation to child:	Today's Date: / /

Who referred this child? _____

What questions or concerns prompted this consultation?

_____

_____

_____

_____

FAMILY HISTORY

Biological Father's Name		Birth date / /
Address		
Occupation		Highest grade completed
Home phone	Work Phone	Can be called at work? □ YES □ NO

Biological Mother's Name		Birth date / /
Address		
Occupation		Highest grade completed
Home phone	Work Phone	Can be called at work? □ YES □ NO

Adopted/Step/Foster Father's Name		Birth date / /
Address		
Occupation		Highest grade completed
Home phone	Work Phone	Can be called at work? □ YES □ NO

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Adopted/Step/Foster Mother's Name		Birth date / /
Address		
Occupation		Highest grade completed
Home phone	Work Phone	Can be called at work? □ YES □ NO

If parents are separated or divorced, what are the custody and visitation arrangements?

_____

_____

If this child is adopted or in foster care:

Age when first in home: _____
Age when adopted: _____
What has this child been told about the foster care/adoption? _____

_____

Are there any unresolved legal/court issues, such as custody, juvenile delinquency charges, adoption?

If yes, please explain: _____

_____

Please list all people living in the same household as this child:

Name	Age	Sex	Relation to child	Grade in school present, or highest grade completed

Please list any other people who spend a significant amount of time with this child (e.g. grandparents, babysitter, friend) _____

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Please list any brothers and sisters who are not currently living at home:

Name	Age	Sex	State of residence	Grade in school present, or highest grade completed

FAMILY HEALTH

Have any biological family/extended family members had any of the following? If yes, please describe the problem, and the person's relationship to this child.

Diabetes	□ Yes □ No
Allergies	□ Yes □ No
Seizures or epilepsy	□ Yes □ No
Ticks or Tourettes Syndrom	□ Yes □ No
Muscular dystrophy	□ Yes □ No
Cerebral palsy	□ Yes □ No
Birth defect	□ Yes □ No
Head injury	□ Yes □ No
Migraine headaches	□ Yes □ No
Physical handicap	□ Yes □ No
Mental retardation	□ Yes □ No
Inattention or Hyperactivity	□ Yes □ No
Behavior problems	□ Yes □ No
In trouble with the law	□ Yes □ No
Drinking problem/drug abuse	□ Yes □ No
Repeated a grade in school	□ Yes □ No

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Reading problem	□ Yes □ No
Speech,language issues	□ Yes □ No
Other learning disability	□ Yes □ No
Depression	□ Yes □ No
Anxiety	□ Yes □ No
Emotional problems	□ Yes □ No
Other health problem	□ Yes □ No
Other serious problem	□ Yes □ No

Describe the current health of this child's parents or guardians:

_____

_____

Compared to other families, the stress level in your home is?

□ Much lower □ Lower □ About the same □ Higher □ Much higher

If married, compared to other couples, the level of satisfaction in your relationship is:

□ Much lower □ Lower □ About the same □ Higher □ Much higher

MEDICAL HISTORY

Age of mother _____ and father _____ at this child's birth.

Number of previous pregnancies ____, miscarriages ____, abortions ____.

Was the mother under a physician's care? □ Yes □ No
Was there difficulty in conceiving? □ Yes □ No

Did mother take/use:	Before knowing she was pregnant	During rest of pregnancy	If yes, please describe type and amount
Prescription medicine	□ Yes □ No	□ Yes □ No	
Street drugs	□ Yes □ No	□ Yes □ No	
Alcohol	□ Yes □ No	□ Yes □ No	

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Tobacco	□ Yes □ No	□ Yes □ No	

Did mom experience any of the following during pregnancy with this child? If so, please describe.

Toxemia	□ Yes □ No
Abnormal weight gain	□ Yes □ No
Measles	□ Yes □ No
German measles	□ Yes □ No
Excessive vomiting	□ Yes □ No
Excessive swelling	□ Yes □ No
Emotional problems	□ Yes □ No
Vaginal bleeding	□ Yes □ No
Flu	□ Yes □ No
Anemia	□ Yes □ No
High blood pressure	□ Yes □ No
Rh incompativility	□ Yes □ No
Maternal injury	□ Yes □ No
Hospitilizations	□ Yes □ No

Were there any of the following problems or complications during delivery? If so, please describe.

Breech birth	□ Yes □ No
Cord around neck	□ Yes □ No
Labor induced	□ Yes □ No
Caesarean delivery	□ Yes □ No
Forceps used	□ Yes □ No
Fetal distress	□ Yes □ No
Breathing problems	□ Yes □ No
Use of incubator	□ Yes □ No
Jaundiced	□ Yes □ No

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Other	□ Yes □ No Describe, if yes:

Length of Pregnancy _____wks; Labor ____hrs. Birth wt. ____lbs., ____oz. Apgar scores ___ /___

Has this child had problems with any of the following? If so, please list age(s), and describe problem.

Problem		Age	Description	Problem		Age	Description
Colic	□Yes □No			Anemia	□Yes □No		
Eating	□Yes □No			Poisoned	□Yes □No		
Projectile vomiting	□Yes □No			Fever > 103	□Yes □No		
Weight	□Yes □No			Sustained fever	□Yes □No		
Sleeping	□Yes □No			Meningitis	□Yes □No		
Wetting (enuresis)	□Yes □No			Encephalitis	□Yes □No		
Soiling (encopresis)	□Yes □No			Scarlet fever	□Yes □No		
Ear infection	□Yes □No			Heart condition	□Yes □No		
Allergies/Asthma	□Yes □No			Head Injury	□Yes □No		
Pneumonia	□Yes □No			Lost consciousness	□Yes □No		
Hearing	□Yes □No			Seizures	□Yes □No		
Vision	□Yes □No			Hospitalization/ER	□Yes □No		

Please list any other significant medical problems, illnesses or operations:

_____

Child's Physician: _____ Phone: _____

Current Regular Medicines				
Medicine	Dose	Taking how long?	Taking for:	Benefits or Side Effects?

Prior Regular Medicines				
Medicine	Dose	Took how long?	Took for:	Benefits or Side Effects?

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DEVELOPMENTAL HISTORY

Developmental Milestones	Approximate Age Achieved	Not Yet	Don't Remember
Turned Over (5-9m)			
Sat Alone (5-10m)			
Crawled (6-12m)			
Stood Alone (9-13m)			
Walked Alone (10-18m)			
Spoke first words other than "mama" or "dada" (9-12m)			
Weaned (6-24m)			
Toilet trained – daytime (18-36m)			
Toilet trained – nighttime (24-60m)			
Controlled bowel movements (18-36m)			
Tied Own Shoes (4-6y)			
Rode Bicycle without training wheels			

Has this child experienced problems with any of the following? If so, please describe.

Speech	□ Yes □ No □ Not Sure
Walking	□ Yes □ No □ Not Sure
Motor skills/coordination	□ Yes □ No □ Not Sure
Temper or arguing	□ Yes □ No □ Not Sure
Excessive crying	□ Yes □ No □ Not Sure
Separating from parents	□ Yes □ No □ Not Sure

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Overly sensitive senses (e.g. to clothing, touch, light, sound, taste, smell)? If so, please describe.

Which hand does this child use for: Writing □Left □Right Eating □L □R Throwing □L □R

SOCIAL HISTORY

Please describe this child's extra-curricular activities (e.g. church, clubs, sports, music, hobbies, job)

Please describe how this child gets along with others (e.g. with parents, other adults, siblings, friends):

Please provide a brief listing of significant events in this child's life, such as age 4 – parents separated, age 6 – held back 1st grade, parent lost job, age 11 – moved.

Age	Event

History or concern about possible physical, sexual, or emotional abuse?

MENTAL HEALTH HISTORY

Outpatient Services (e.g. counselor, psychologist, psychiatrist)			
With whom/where	When	How Long	Results

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Hospitalization			
Where	When	How Long	Results

Agency or Organization Services (e.g. Wraparound, TSS, Head Start)			
With whom/where	When	How Long	Results
Testing Services (e.g. psychological, academic, speech, OT/PT)			
With whom/where		When	

Please obtain and send us a copy of prior testing reports.

EDUCATIONAL HISTORY

Current Grade _____ Current School _____

To the best of your knowledge, at what grade level is this child functioning in:
Reading? _____ *Spelling?* _____ *Arithmetic?* _____

Please list special educational services (e.g. Resource Room, Learning Support, Gifted) and classes covered:

_____

_____

Other academic issues:		If yes, please describe:
Speech/Language Therapy?	□ Yes □ No □ Not Sure	
Physical/Occupational Therapy?	□ Yes □ No □ Not Sure	
Trouble with handwriting?	□ Yes □ No □ Not Sure	
Private tutoring now or in past?	□ Yes □ No □ Not Sure	

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Programs (Sylvan, Phonics Game, etc)	□ Yes □ No □ Not Sure	
Tested in school in past 2 years?	□ Yes □ No □ Not Sure	
Grades skipped or repeated?	□ Yes □ No □ Not Sure	
Is attendance a problem?	□ Yes □ No □ Not Sure	
Is behavior a problem at school?	□ Yes □ No □ Not Sure	
Suspended or expelled?	□ Yes □ No □ Not Sure	
Is homework a problem?	□ Yes □ No □ Not Sure	

Please record progress or problems during:

Pre-School & Kindergarten

1st – 3rd grades

4th – 6th grades

7th – 8th grades

9th – 12th grades

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MISCELLANEOUS

At what age did you or others first notice this child's difficulties? _____
What do you think caused this child's problem(s)? _____

_____

What have you been told by doctors, teachers, or others about this child's problems?

_____

_____

How serious do you think this child's problem(s) is (are)?

□ No problem □ Minor problem □ Moderate problem □ Serious problem

Compared to other children his/her age, this child's activity level is:

□ Much lower □ Lower □ About the same □ Higher □ Much higher

Compared to other children his/her age, this child's self-control is:

□ Extremely poor □ Poor □ Adequate □ Good □ Very good

What is the most effective discipline used with this child? _____

_____

If there is a spouse or other adult in the same household as you and this child, how much do you and this person agree on discipline?

□ Not at all □ A little □ A fair amount □ Most of the time □ All the time

What do you like about this child?

_____

_____

_____

_____

_____

_____

_____

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