Parent Questionnaire

Child's Name: _____ **Nickname:** _____

Child's Birth Date: _____ **Age:** _____ **Grade:** _____

Child's School: _____

Daycare: _____

Whose idea was it to have this evaluation? _____

_____

_____

_____

_____

What specific problems would you like help with?

1. _____

2. _____

3. _____

Mother's Name: _____ **Contact #:** _____

Father's Name: _____ **Contact #:** _____

Parents are (please circle): Married Separated Divorced
Living Together Never Married Other

If parents live separately, please describe custody and visitation: _____

_____

_____

_____

_____

Please list all members living in (each) household (Name/Age/Relation):

Household 1	Household 2 (if applicable)

Is your child adopted? _____ **If so, is your child aware of this?** _____

Is there anything that you do not want to discuss in front of your child at the appointment?

Please describe your child's personality, strengths and talents:

Please list your child's interests:

Mother's age at delivery: _____ **Father's age at delivery:** _____
Number of previous pregnancies: _____
Previous miscarriages: _____ **Previous premature baby:** _____

Was your child full term? _____ **If not, how many weeks at delivery?** _____
Birth weight: _____
If twin or triplet, list order of delivery: _____

Check if any of the following conditions occurred during pregnancy:

□ Bleeding during pregnancy: 1st, 2nd, 3rd trimester (circle if applicable)

□ Toxemia or pre-eclampsia

□ Gestational Diabetes: controlled with diet, insulin, both (circle if applicable)

□ Serious illness. If yes, please describe: _____

□ Took prescription medications. If yes, please list: _____

□ Took illegal drugs or narcotics. If yes, what? _____

□ Drank alcohol. If yes, how many drinks a week? _____

□ Smoked cigarettes. If yes, how many a day? _____

Check if any of the following conditions occurred during labor and/or delivery:

□ Cesarean delivery: If yes, for what reason? _____

□ Forceps use

□ Vacuum use

□ Breech (feet first)

□ Fever in mother

□ Other problem. Please describe: _____

Check if there were any of the following newborn conditions:

□ Required the use of oxygen at or after delivery.

□ Hospital stay longer than 7days. If yes, how many days? _____

□ Trouble breathing

□ Infection

□ Seizures

□ Medication needed

□ Jaundice (yellow skin tone): If so, what treatment? _____

Does your child have any diagnosed medical conditions? If yes, please describe: _____

_____

Past Hospitalizations/ Surgeries: _____

_____

_____

Current Medications taken (over the counter, vitamins, and prescriptions):_____

_____

_____

_____

_____

_____

Medication Allergies: _____

Please check if any of the following conditions have occurred:

□Frequent ear infections

□ Snoring during sleep

□ Breathing stops during sleep

□ Frequent body aches or headaches

□ Frequent visits to the school nurse

□ Constipation or diarrhea

□ Difficulty toilet training

□Problems with bed-wetting

□ Concerns of gaining too much weight

□ Difficulty gaining weight

□ Trouble with spitting up, gagging or choking on foods

□ Frequent falls, injuries, accidents

□Head trauma/ Concussion

□ Seizures or Staring spells

□ Tics or twitches (muscle movements your child cannot control)

□ "Growing pains"

□ Chest pain or trouble breathing when exercising or at rest

□ Fainting, passing out, loss of consciousness

□ Heart murmur or heart problem

□ Elevated lead level, any lead in blood

□ Abnormal results from newborn screening ("PKU test", heel prick test)

□Loss of milestones already obtained (stopped talking or stopped doing something)

Date of last hearing test:_____

What were the results?_____

Date of last vision test:_____

Does your child need glasses?_____If yes, does your child wear the glasses?_____

Do you have any concerns about your child's sleep? _____

If yes, please explain**:** _____

Does your child have his/her own room? _____

If not, with whom does your child share a room? _____

What time does your child get into bed at night? _____

What time does your child fall asleep at night? _____

What time does your child wake up during the week? _____ **On weekends?** _____

Does your child sleep in his/her own bed all night? _____

Does your child nap? _____ If yes, what time/where? _____

Are there any concerns about your child's appetite or growth? _____

If yes, please describe: _____

Did your child have any developmental delay? _____

Did your child have low tone/ hypotonia? _____

Is your child uncoordinated or clumsy? _____

How old does your child appear to act? _____

Handedness: Right Left No dominant hand

Please circle one of the following for how old your child was for the following:

Walking:	By 14 months	14-18 months	after 18 months
Able to undress:	By 2 years	2-3 years	> 3 years
Able to dress self:	By 4 years	4-5 years	>5 year
Toilet trained (day):	By 4 years	4-5 years	> 5 years
Able to tie shoelaces:	By 5 years	5- 6 years	> 6 years
Responded to name:	By 1 year	12-18 months	>18 months
Said "mama/dada" to call you:	By 1 year	12-14 months	>14 months
Said 1 word (other than a name):	By 1 year	12- 14 months	> 14 months
Put 2 words together:	By 18 months	18-24 months	> 24 months

Check which applies to your child's temperament as an *infant* (0-12 months old)

□ Generally happy
□ Very active
□ Colic, cried a lot
□ Slow to warm up to new people/environments
□ "Too good", never cried, did not demand much

Has your child received any early intervention services through Infants and Toddlers?_____
If yes, please circle services received: Speech and Language Occupational Therapy
Physical Therapy Special instruction Other:

Has your child ever received formal testing by the school or privately in any of the following areas? (If yes, please record results and bring copies to the appointment)

□ **Psychological/Neuropsychological** (for example, IQ testing and/or behavioral testing)_____

□ **Speech and Language**_____

□ **Occupational Therapy**_____

□ **Academic or Educational Assessment**_____

□ **Physical Therapy**_____

□ **Adaptive Technology Assessment**_____

Please list where your child has received daycare/education:

Head Start/ Preschool/ Nursery School:_____
Age:_____ Location:_____

Pre- Kindergarten:_____
Age:_____ Location:_____

Kindergarten:_____
Age:_____ Location:_____

Elementary School:_____
Age:_____ Location:_____

Middle School:_____
Age:_____ Location:_____

High School:_____
Age:_____ Location:_____

Has your child ever repeated a grade? _____
Does your child have a 504 plan?_____
Does your child have an IEP? _____
If yes, for what? _____(please bring to the appointment)

Please list any specialists that your child has seen (genetics, neurology, developmental pediatrics, psychiatry, psychology/therapy) and/or any other medical work up (blood work, MRI, CT, EEG, EKG etc..) that has been done with the results.

If you would like to discuss medication management, please list previous medications and doses.

	Age	Problems in School or difficulty learning	Highest Degree and Current Employment	Mental or Emotional Health problems (anxiety, substance abuse)
Mother				
Father				
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				
Mother's Sisters				
Mother's Brothers				
Father's Sisters				
Father's Brothers				

Please list your child's siblings:

Name	Age	Grade	School or learning difficulties/mental health concerns

Please check if there has ever been concern about the following in the family. Write who this person is in relationship to the child (ie- mother, brother, maternal uncle…)

□ ADHD or problems with hyperactivity, impulsivity, or attention _____

□ Trouble with reading_____

□ Trouble with math _____

□Trouble with writing _____

□Kept back a grade in school _____

□ Did not graduate high school _____

□Speech problems _____

□ Intellectual Disability (Mental Retardation)_____

□ Autism _____

□ Depression _____

□ Suicide _____

□ Anxiety (Worrying too much)_____

□ Bipolar (manic-depressive) _____

□Schizophrenia _____

□Troubles with law: assaults, thefts, arrests _____

□Seizures _____

□Tics or Tourette's Syndrome _____

□Drug or alcohol problem _____

□Obsessive-compulsive behavior _____

□ Physical or sexual abuse _____

□ Premature Death (prior to age 50) from a heart related illness (heart attack or stroke)_____

□ Congenital heart disease (abnormal heart from birth)_____