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Parent Questionnaire

Please answer the following questions carefully and completely.

Your answers will help us greatly in our understanding of your child.

The questionnaire will be reviewed with you, so it will be possible to discuss your answers if you wish.

Child's name: _____ Date: _____

Nickname: _____ Age: _____ Date of birth: _____

Name of legal guardians: _____

Person completing form: _____ Relation to child: _____

How were you referred? _____

Problems and Concerns

Please list, in order of urgency, the problem(s) for which you are seeking help for your child:

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

Family History

1. Who is this child currently living with? (check all that apply)

- both natural parents
- natural mother
- natural father
- grandparent
- circle: grandmother, grandfather
- mother's side, father's side
- stepmother
- stepfather
- foster parents
- adoptive parents
- other (describe) _____

2. Parental information

	Mother	Father
<u>Occupation:</u>		
<u>Business phone:</u>		
<u>Age:</u>		
<u>Highest grade completed:</u>		
History of the following (please explain):		
<u>Learning problems:</u>		
<u>Attention problems:</u>		
<u>Behavior problems:</u>		
<u>Emotional/psychiatric problems:</u>		
<u>Medical problems:</u>		
<u>Prescriptions used for past/present psychiatric/psychological problems:</u>		

3. List all people living in the child's home?

Name	Age	Relation to child

4. Other brothers and sisters not at home (natural, step, and other siblings)?

Name	Age	Relation to child	Occupation

5. Information about all parents (including step-parents or other parenting figures):

Name	Age	Education	Occupation	Frequency of contact

6. Please list the important changes that have occurred in your child's lifetime (for example: deaths, marital separations, divorces, remarriages, family moves, loss of important friendships, serious illnesses, financial problems, periods of parental conflict, family violence, etc.). Please provide specific dates during which each event occurred and identify the persons involved.

Dates or ages	Changes

7. List any other events that, in your opinion, have had important meaning or significant impact on your child or your family. If you are uncertain about the significance, please list it anyway.

Dates or ages

Changes

Pregnancy

1. Was the pregnancy: planned unplanned
(check all that apply) wanted unwanted
 with prenatal care without prenatal care

2. Age of parents at time of child's birth: _____mother _____father

3. While mother was pregnant, did she have any of the following difficulties?

- | | |
|--|---|
| <input type="checkbox"/> measles | <input type="checkbox"/> very overweight |
| <input type="checkbox"/> frequent nausea or vomiting | <input type="checkbox"/> very underweight |
| <input type="checkbox"/> swelling or toxemia | <input type="checkbox"/> heart trouble |
| <input type="checkbox"/> flu, infections, high fever | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> hospitalizations | <input type="checkbox"/> financial problems |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> marital problems |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> family problems |
| <input type="checkbox"/> headaches | <input type="checkbox"/> other social problems: |
| <input type="checkbox"/> spotting or bleeding | <input type="checkbox"/> nervous |
| <input type="checkbox"/> depressed | <input type="checkbox"/> worried |
| <input type="checkbox"/> chronic disease _____ | |
| <input type="checkbox"/> accidents/injuries _____ | |
| <input type="checkbox"/> surgeries _____ | |
| <input type="checkbox"/> medications _____ | |
| <input type="checkbox"/> alcohol intake _____ | |
| <input type="checkbox"/> drug use _____ | |
| <input type="checkbox"/> exposure to toxic chemicals or substances _____ | |
| <input type="checkbox"/> stressful events for one or both parents _____ | |

Delivery

1. How long did labor last: _____ 2. Baby's weight at birth: _____
3. Was baby full term? _____ If not, how many weeks premature? _____
4. Describe the father's role in the delivery: _____
5. Length of hospital stay for mother? _____ Length of stay for child? _____
6. Were any of the following present during or soon after delivery? (check all that apply)
- | | |
|---|---|
| <input type="checkbox"/> mother was put to sleep | <input type="checkbox"/> baby was jaundiced (yellow) |
| <input type="checkbox"/> C Section performed | <input type="checkbox"/> baby aspirated meconium (breathed waste) |
| <input type="checkbox"/> Instruments used to deliver | <input type="checkbox"/> baby needed blood |
| <input type="checkbox"/> Rh factor present | <input type="checkbox"/> baby needed oxygen |
| <input type="checkbox"/> breech birth or presentation | <input type="checkbox"/> baby had trouble sucking |
| <input type="checkbox"/> born with cord around neck | <input type="checkbox"/> baby had trouble keeping food down |
| <input type="checkbox"/> baby was blue | |
| <input type="checkbox"/> baby was placed in an incubator. For how long? _____ | |
| <input type="checkbox"/> other medical problems at birth (describe): _____ | |

Developmental History

1. Did any of the following occur during infancy?
(check all that apply) please describe
- | | |
|---|--|
| <input type="checkbox"/> baby had problems sleeping _____ | |
| <input type="checkbox"/> baby was frequently fussy or colicky _____ | |
| <input type="checkbox"/> baby had unusual crying _____ | |
| <input type="checkbox"/> baby had trouble breathing _____ | |
| <input type="checkbox"/> baby had problems eating or gaining weight _____ | |
| <input type="checkbox"/> baby experienced convulsions, seizures, or "spells" _____ | |
| <input type="checkbox"/> baby had excessive diarrhea or dehydration _____ | |
| <input type="checkbox"/> mother was depressed, anxious, or unusually stressed _____ | |
| <input type="checkbox"/> mother was physically ill or injured _____ | |
2. Who was primarily responsible of baby's caretaking? _____
- Who assisted in the baby's care? _____

3. During your child's first year of life, was there anything (even if it had nothing to do with the baby) that caused unhappiness in the family, or placed the mother or father under special strain?

4. Did mother (or primary caretaker) work before this child entered school? ____yes ____no

If yes, who cared for this child while the mother worked?

- babysitter
- family member
- day care center(s)

ages

location

5. How do you feel your child developed in the following areas?

- | | | | |
|--------------------------------------|--|----------------------------------|--|
| physical & motor development | <input type="checkbox"/> faster than average | <input type="checkbox"/> average | <input type="checkbox"/> slower than average |
| talking & language development | <input type="checkbox"/> faster than average | <input type="checkbox"/> average | <input type="checkbox"/> slower than average |
| relationships and social development | <input type="checkbox"/> faster than average | <input type="checkbox"/> average | <input type="checkbox"/> slower than average |

6. Estimate the age at which the following occurs (please leave blank if you cannot remember):

Age

- _____ smiled
- _____ held head up
- _____ sat without support
- _____ stood up
- _____ took first steps
- _____ walked alone
- _____ weaned

Age

- _____ spoke first word
- _____ spoke in phrases
- _____ spoke in sentences
- _____ toilet trained—bladder
- _____ toilet trained—bowel
- _____ dressed self

comments: _____

School History

1. Current grade: _____ School District: _____

2. Did your child attend day care? _____ How old was your child when s/he started? _____

If yes, describe the setting and the child's reaction to it? _____

3. Please list below the day care centers, preschools, and schools attended:

<u>School</u>	<u>Location (City, State)</u>	<u>Ages/Grade</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. As best you can recall, please use the following space to provide a general description of your child's school progress in each grade.

- Pre-K _____
- Kinder _____
- First _____
- Second _____
- Third _____
- Fourth _____
- Fifth _____
- Sixth _____
- Seventh _____
- Eighth _____
- Ninth _____
- Tenth _____
- Eleventh _____
- Twelfth _____

5. Has your child ever repeated a grade? yes no If yes, what grade and what was the reason?

6. Please write the grade in which your child may have received any of the following services in school:

_____ Head Start _____ Early reading program (Title I) _____ Speech Therapy
_____ Physical Therapy _____ Occupational Therapy _____ School Counselor
_____ Resource Room _____ Content Mastery Center _____ Special Education

Special Education Qualification: (mark all that apply)

MR LD OHI TBI VI SI OI ED

Please list any academic subjects that were addressed with these services:

7. Please rate your child's current school performance (for children ages 6 and older)

<u>Subject</u>	<u>failing</u>	<u>below average</u>	<u>average</u>	<u>above average</u>
Reading or English	_____	_____	_____	_____
Writing	_____	_____	_____	_____
Arithmetic or Math	_____	_____	_____	_____
Spelling	_____	_____	_____	_____
Other:	_____	_____	_____	_____

8. Please describe any changes in your child's academic performance, either recently or over the course or his/her school career:

9. School homework for this child: (check those that apply)

comments

- Is something s/he enjoys doing. _____
- Is a source of unhappiness and trouble. _____
- Is something s/he has to be forced to do. _____
- Is something father helps with most. _____
- Is something mother helps with most. _____

10. Your child usually studies:

Where? _____

When? _____

How long? _____

11. Describe any academic or other problems your child has had in school:

Temperament

1. What are the qualities you like best about your child as a preschooler?

2. What are some troublesome qualities you noticed about your child as a preschooler?

3. What are the qualities you like best about your child now?

4. What are some troublesome qualities you notice about your child now?

Medical History

1. Has your child had any serious illnesses, injuries, or accidents?

Type

Age

2. Has your child ever been hospitalized?

Reason

Age

3. Please write the ages (in years) that your child had any of the following illnesses:

<u>Ages</u>	<u>Ages</u>	<u>Ages</u>
_____ Allergies	_____ head injuries	_____ pneumonia
_____ Asthma	_____ heart trouble	_____ prolonged colic
_____ blood transfusion	_____ high fever	_____ tonsillitis
_____ convulsions/ seizures	_____ infections (meningitis, encephalitis)	_____ frequent ear aches
_____ diabetes	_____ major fractures	_____ frequent colds/ sore throats
_____ fainting	_____ menstrual problems	_____ tics, twitching
_____ frequent stomach aches	other: _____	

4. My child's physicians are:

5. My child's present medications are:

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Please describe any problems your child may have had in the following areas:

age of last exam

vision: _____

hearing: _____

speech: _____

7. Please describe your child's eating habits. Note any problems in this area.

8. Please describe your child's sleeping habits. (Please note any problems going to sleep, sleeping alone, night awakenings, length of sleep, nightmares, sleepwalking, etc.)

9. Has your child ever received the following professional services?

<u>Ages</u>	<u>Services</u>	<u>Name of Professionals</u>
_____	Psychological	_____
_____	Psychiatric	_____
_____	Neurological	_____
_____	Counseling/Therapy	_____
_____	Educational	_____

10. Please list anyone in the child's extended family who has had difficulties with:

<u>Problem</u>	<u>Relationship to child</u>
emotional problems	_____
depression	_____
extreme nervousness	_____
explosive temper	_____
convulsions or seizures	_____
extreme shyness	_____
mental retardation	_____
learning disability, dyslexia	_____
hyperactivity	_____
problems paying attention	_____
drinking problem/alcoholism	_____
drug problem/addiction	_____
criminal record	_____
victim of spouse abuse	_____
spouse abuser	_____
sexual abuser	_____
victim of sexual abuse	_____
sleep problems	_____

4. Please list any jobs or chores that your child has: (For example, baby-sitting, paper route, making bed, etc)

5. Write the first name(s) of this child's close friend(s):

How many times a week are they together? _____

What are their typical activities? _____

6. Please list any organizations, clubs, teams, or groups that your child belongs to:

7. Please list your child's special interests, hobbies, or activities:

8. Please list your child's special strengths, talents, abilities:

9. Please describe any unusually positive or negative relationships this child has with important people in his/her life:
