dr. taylor

NEUROPSYCHOLOGY

Parent Questionnaire

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:_____
_____
_____
_____

FAMILY BACKGROUND

Who is this child currently living with? (Mark all that apply):

__ Both Natural Parents	__ Natural Mother	__ Natural Father	__Other (specify)
__ Foster parents	__ Stepmother	__ Stepfather	_____
__ Adoptive Parents	__ Grandmother	__ Grandfather	_____

List all people living in the child's home:
Name: _____ Age: _____ Relation: _____
Name: _____ Age: _____ Relation: _____
Name: _____ Age: _____ Relation: _____

List all people living in the child's home (cont.):

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Name: _____ Age: _____ Relation: _____

Other brothers and sisters NOT at home (natural, step, and other siblings):

Name: _____ Age: _____

Relation: _____ Occupation: _____

Name: _____ Age: _____

Relation: _____ Occupation: _____

Name: _____ Age: _____

Relation: _____ Occupation: _____

Name: _____ Age: _____

Relation: _____ Occupation: _____

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

Name: _____ Age: _____

Occupation: _____ Frequency of Contact: _____

Name: _____ Age: _____

Occupation: _____ Frequency of Contact: _____

Name: _____ Age: _____

Occupation: _____ Frequency of Contact: _____

Name: _____ Age: _____

Occupation: _____ Frequency of Contact: _____

Please describe important changes that have occurred in your child's lifetime, (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 such event(s) occurred, identify the person(s) involved, and specify what age the child was when the event took place.

_____

_____

_____

_____

_____

List any other events that, in your opinion, have had important meaning or significant impact on your child or family. If you are uncertain about the significance, please list it anyway. Please be specific in regards to date, age, and any changes noted afterwards.

PARENTAL INFORMATION

Father

Age: _____ Highest Level of Education:_____

Occupation: _____

Email: _____ Phone: _____

Please describe any known history of learning, attention, behavioral, emotional/psychiatric, or medical, problems and indicate any past or current medications and prescriptions used to treat.

Mother

Age: _____ Highest Level of Education:_____

Occupation: _____

Email: _____ Phone: _____

Please describe any known history of learning, attention, behavioral, emotional/psychiatric, or medical, problems and indicate any past or current medications and prescriptions used to treat.

Pregnancy

Was the pregnancy (Mark all that apply):

___ Planned	___ Wanted	___ With Prenatal Care
___ Unplanned	___ Unwanted	___ Without Prenatal Care

While mother was pregnant, did she have any of the following difficulties? (Mark all that apply):

__ Heart Trouble	__ Kidney Disease	__ Financial Struggles	__ Measles
__ Headaches	__ Venereal Disease	__ Marital Struggles	__ Anxious
__ Overweight	__ Nausea/Vomiting	__ Social Struggles	__ Diabetes
__ Underweight	__ Spotting/Bleeding	__ Swelling/Toxemia	__ Worried
__ Pneumonia	__ High Blood Pressure	__ Depressed	__High Fever

If below items are checked, please specify

___ Chronic Illness: _____
___ Accidents/Injuries: _____
___ Surgeries:_____
___ Medications: _____
___ Alcohol Intake:_____
___ Drug Use:_____
___ Exposure to toxic chemicals or substances: _____
___ Stressful events for one or both parents: _____
_____

Delivery

How long did labor last:_____ Baby's weight at birth: _____
Was the baby full term? ___Yes ___No If no, how many weeks premature:_____
Length of hospital stay for mother:_____
Length of stay for child:_____

Were any of the following present during or soon after delivery? (Mark all that apply):

___ C-Section Performed
___ Baby needed blood
___ Baby needed oxygen
___ Baby was jaundiced
___ RH Factor Present
___ Baby was blue
___ Baby aspirated meconium
___ Baby had trouble keeping food down
___ Baby had trouble latching/sucking
___ Breech birth or presentation
___ Born with cord around neck
___ Instruments used to deliver
___ Baby was placed in an incubator. For how long?_____
___ Other medical problems at birth (please describe) _____

DEVELOPMENTAL HISTORY

Did any of the following occur during infancy? (Mark all that apply):

___ Baby had problems sleeping
___ Baby was often fussy or cockily
___ Baby had trouble breathing
___ Baby had unusual crying
___ Mother was physically ill or injured
___ Baby experienced convulsions/seizures
___ Baby had excessive diarrhea/dehydration
___ Baby had problems eating/gaining weight

Who was primarily responsible for the baby's caretaking?_____
Who, if anyone, assisted in the baby's care? _____

How do you feel your child developed in the following areas? (Circle the best choice):

- Physical & Motor Development	Early	Normal	Late
- Talking & Language Development	Early	Normal	Late
- Relationships & Social Development	Early	Normal	Late

Estimate the age at which the following occurred (leave blank if you can't remember):

____ Smiled
____ Stood up
____ Weaned
____ Dressed self
____ Spoke first word
____ Spoke in phrases
____ Spoke in sentences
____ Walked alone
____ Held head up
____ Sat without support
____ Potty trained–bladder
____ Potty trained–bowel

MEDICAL HISTORY

Has your child had any illnesses, injuries, or accidents? ___ Yes ___ No

Explain, include what type of accident(s) and the child's age(s) at the time:

Has your child ever been hospitalized? ___ Yes ___ No

Explain, include the reason(s) and the child's age(s) at the time:

Specify in years at what age your child had any of the following illnesses:

____ Allergies	____ Head Injuries	____ Asthma	____ Pneumonia
____ High Fever	____ Blood Transfusion	____ Fainting	____ Diabetes
____ Heart Trouble	____ Tonsillitis	____ Fractures	____ Tics/twitching
____ Prolonged Colic	____ Stomach Aches	____ Convulsions/seizures	
____ Menstrual Problems	____ Frequent Infections	____ Frequent cold/sore throat	

____ Other: _____

My child's physician(s) are:

_____

_____

List **present** medications, supplements, or vitamins your child currently takes:

1._____

Dosage:_____ Frequency:_____

2._____

Dosage:_____ Frequency:_____

3._____

Dosage:_____ Frequency:_____

4._____

Dosage:_____ Frequency:_____

5._____

Dosage:_____ Frequency:_____

6._____

Dosage:_____ Frequency:_____

List **past** medications, supplements, or vitamins your child has previously taken:

1._____

Dosage:_____ Frequency:_____

2._____

Dosage:_____ Frequency:_____

3._____

Dosage:_____ Frequency:_____

4._____

Dosage:_____ Frequency:_____

5._____

Dosage:_____ Frequency:_____

6._____

Dosage:_____ Frequency:_____

Has your child had a speech evaluation?	____ Yes	____ No	Date: _____
Has your child had a hearing test?	____ Yes	____ No	Date: _____
Has your child had a vision test?	____ Yes	____ No	Date: _____

Please describe your child's eating habits and note any problems in this area.

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Has your child ever received any of the following services? (Mark all that apply):

___Psychological ___Psychiatric ___Neurological
___Educational ___Counseling/Therapy

Name of professional: _____ Age seen: _____
Name of professional: _____ Age seen: _____
Name of professional: _____ Age seen: _____
Name of professional: _____ Age seen: _____

Please list if anyone in the child's extended family has had any medical or mental health diagnoses such as: depression, ADHD, learning disorder, autism, etc.

Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____
Relation:_____ Diagnoses:_____

SCHOOL HISTORY

Current grade:_____ Name of School:_____
School District:_____
Did your child attend daycare? ___ Yes ___ No
If yes, describe the setting and the child's reaction to it:

_____

_____

_____

How old was your child when they started daycare?_____

List any *past and current* day care centers, preschools, and schools attended:
School: _____
Ages: _____ Grade: _____ Location (City, State): _____
School: _____
Ages: _____ Grade: _____ Location (City, State): _____
School: _____
Ages: _____ Grade: _____ Location (City, State): _____
School: _____
Ages: _____ Grade: _____ Location (City, State): _____

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
Comments:_____

_____

Kinder
Name of School: _____ District:_____
Comments:_____

_____

1st

Name of School: _____ District: _____

Comments: _____

_____

2nd

Name of School: _____ District: _____

Comments: _____

_____

3rd

Name of School: _____ District: _____

Comments: _____

_____

4th

Name of School: _____ District: _____

Comments: _____

_____

5th

Name of School: _____ District: _____

Comments: _____

_____

6th

Name of School: _____ District: _____

Comments: _____

_____

7th

Name of School: _____ District: _____

Comments: _____

_____

8th

Name of School: _____ District: _____

Comments: _____

_____

9th

Name of School: _____ District:_____

Comments:_____

_____

10th

Name of School: _____ District:_____

Comments:_____

_____

11th

Name of School: _____ District:_____

Comments:_____

_____

12th

Name of School: _____ District:_____

Comments:_____

_____

Has your child ever repeated a grade? ___ Yes ___ No

If yes, what grade and what was the reason:

_____

_____

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

___ School Counselor ___ OT (Occupational Therapy) ___ ST (Speech Therapy)

___ Special Education ___ PT (Physical Therapy) ___ Head Start

___ Resource Services

Special Education Qualification: (Mark all that apply):

___ID ___LD ___OHI ___TBI ___VI ___SI ___OI ___ED

Please list any academic subjects that were accommodated or modified with these services:

_____

_____

Circle the best choice in regards to your child's *current* school performance (ages 6+):

Language Arts or Reading:	Below Avg	Average	Above Avg.
Writing or Spelling:	Below Avg	Average	Above Avg.
Math or Arithmetic:	Below Avg	Average	Above Avg.
Science:	Below Avg	Average	Above Avg.
History:	Below Avg	Average	Above Avg.
Other:_____	Below Avg	Average	Above Avg.

Please describe any changes in your child's academic performance, either recently or over the course of their school career:

_____

_____

_____

_____

School homework for my child (Mark all that apply):

___ Is something they enjoy doing
___ Is something that has to be forced
___ Is something mother helps with most
___ Is a source of trouble and unhappiness
___ Is something father helps with most

My child usually studies:
Where: _____ When: _____
For how long:_____

Please describe any academic or other problems your child has had in school:

_____

_____

_____

_____

TEMPERAMENT

What are some qualities you like(d) best about your child as a toddler?

What are some troublesome qualities you notice(d) about your child as a toddler?

What are some qualities you like best about your child now?

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

DISCIPLINE

Who is this child disciplined by? (Please list all if there are multiple disciplinarians):

Discipline method(s) most often used (in order of frequency):

Discipline that is most effective with this child:

Describe how this child reacts to punishment:

_____

_____

_____

_____

SOCIAL FUNCTIONING

Compared to other children your child's age, how well does your child:

Get along with brothers/sisters:	Poor	Average	Great
Get along with other children:	Poor	Average	Great
Behave towards parents:	Poor	Average	Great
Play/work by self:	Poor	Average	Great
Behave in public (restaurants, etc.):	Poor	Average	Great
Behave with baby-sitters (if applicable):	Poor	Average	Great
Behave at daycare (if applicable):	Poor	Average	Great

How does your child relate to others?

_____

_____

How does your child relate to parents?

_____

_____

Please list any jobs or chores that your child has around the house:

_____

_____

What are the first name(s) of your child's close friend(s):

_____

_____

How many times a week are they together?

What are their typical activities?

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

Please list any special interests, hobbies, or activities your child has:

Is time spent gaming, on social media, or general device usage an issue for your child? If so, please describe:

Please list any special strengths, talents, or abilities your child possesses:

Please describe any unusually positive or negative relationships this child has with important people in their life:

Please note any other important information about your child or your family that you think might be important in understanding the problems that have brought you to seek treatment:

That's it, you've made it to the end! Thank you for taking the time to complete this questionnaire. Your input is greatly appreciated!

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