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Child/Parent Questionnaire

This questionnaire concerns you and your child. I am asking you to complete this questionnaire to assist me in focusing on the concerns you have, and to better understand your child. Some of the information requested may not seem related to your child and his/her problems, but often such seemingly unrelated information becomes very important in my understanding your questions. You may not immediately remember the answers to all of the questions. However, I would appreciate your trying to complete the questionnaire as accurately and completely as possible. Family members, baby books, and close friends etc., are all resources, which may be of value in obtaining this information. If you run out of space in answering a question, please use the back of the sheet.

Your completion of this questionnaire **will help cut down on the time needed to make an accurate evaluation of your child's difficulties** as well as help to focus my attention to your most relevant concerns. If you do not understand any of the questions please feel free to call me.

Date: _____

Child's Name: _____ Birthdate: _____ Age:_____
Gender: Male FemaleGrade: _____ School: _____
Home address: _____ Home phone: _____
_____
City State Zip Code

Mother's Name: _____ Birthdate: _____
Biological, Adoptive or Step-mother
Age: _____ Occupation: _____ Religion: _____
Ethnic Background: _____ Years in School: _____
Place of Birth: _____ Date of this marriage:_____
Place employed: _____ How Long:_____
Work Hours: _____ Work Phone: _____

Father's Name: _____ Birthdate: _____
Biological, Adoptive or Step-father
Age: _____ Occupation: _____ Religion: _____
Ethnic Background: _____ Years in School: _____
Place of Birth: _____ Date of this marriage: _____
Place employed: _____ How Long:_____
Work Hours: _____ Work Phone: _____

Who referred you to me? _____

What is it that concerns you most about your child? What problems are you having?
_____
_____
_____
_____
_____

When did these concerns begin? _____

Describe what you have tried to do about these problems: _____
_____
_____
_____

In what other ways do you think your child can best be helped?
_____
_____
_____

In what ways are these problems affecting yourself, other family members or your family as a whole?

_____
_____
_____

Birth History

Did you have problems getting pregnant? _____
Was this a planned pregnancy? _____ How did you feel about it? _____
_____

During which month did you start prenatal care? _____ Where? _____

Did you take any medications during pregnancy (includes all medications, vitamins, birth control pills, etc...) _____
_____

Did you smoke during pregnancy? _____ If so, when? _____
How many cigarettes a day? _____
How much alcohol did you consume during your pregnancy? _____
Number of drinks a week: _____
Any drug use during or prior to pregnancy? _____
Any illnesses? _____
_____

The baby was born: on time early* late* By how many weeks? _____
Length of labor in hours: _____ Length of hard labor: _____
Type of pain control: _____
Type of delivery: Vaginal___ Breech ___ Cesarean ___ Forceps ___
Baby's birth weight _____ Length _____APGAR scores _____
Infant's condition: Breathed immediately ____ Cried immediately _____
Required oxygen ____ Seizures _____
Intensive Care ____

Problems during the first week of life: Incubator ___ Yellow skin ___
Bleeding ____ Infection ____ Special concerns: _____

Later hospitalizations of child (Name of hospital, dates & reason):
_____
_____
_____

Child's Health History

Did the child eat well? _____
Sleep patterns: _____
_____

Childhood diseases: (list age)
Mumps _____ 3-day measles _____
Chicken pox _____ 7-day measles _____
Roseola _____ Scarlet fever _____
Whooping cough _____ Serious illness _____
List any unusual complications: _____

Immunizations:
DPT series ____ Small pox ____ Polio ____ Measles ____
DPT booster ___ Mumps ____ Hepatitis B ___

Please **mark if** your child has had any of the following:
Accidents: _____
High fever, unknown cause: _____
Pneumonia: _____
Anemia: _____
Lead poisoning: _____
Urine infection: _____
Bowel disease: _____
Problem in bladder or bowel control: _____
Vision problems: _____
Hearing: _____
Frequent ear infections: _____
Speech problems: _____
Difficulties eating or feeding self: _____
Difficulties in: Swallowing ____ Chewing ___ Drooling ___
Foot problems: _____

Motor problems: _____
Skin abnormality: _____
Allergies: _____
Seizures or convulsions: _____
Sleep difficulties: _____
Unusual fears: _____
Unusual behaviors: _____

Ingestion of drugs, cleaners or non-food items: _____
Other illnesses/problems: _____
_____

Name & address of physician: _____
_____
Does this physician know your child well? _____ yes _____ no
Does your child take any medication? _____
_____
_____

When was your child's last physical exam? _____

Developmental History

Please indicate the age in months when your child first did each of the following.
If your child has not yet done it please write "No"; if you do not remember, write "DR".

Held head erect _____
Rolled over front to back _____
Rolled over back to front _____
Stood alone _____
Walked holding on furniture _____
Walked without holding on _____
Ran with good control _____
Walked up steps _____
Rode a tricycle _____
Said mama or dada _____
Said three word sentences _____
Ended toilet training _____
Is your child left or right handed? _____

Sat alone _____
Crawled _____
Pulled to stand _____
Smiled spontaneously _____
Feed self cracker _____
Drank from a cup _____
Played peek-a-boo _____
Recognized parents _____
Showed fear with strangers _____
Spoke in two word sentences _____
Started toilet training _____
Put on clothes _____

School History

Has your child ever been in preschool? _____
List where and at what age:
_____
_____
_____
Inorder of attendance, list all of the schools your child has attended since kindergarten:

School: Location Grade Dates
_____

_____
_____
_____
_____

Has your child ever been held back a grade in school? _____ Grade held: ____
Has there ever been a problem in getting your child to go to school? _____
Has your child ever been in special education? _____ If so, when, where, what kind:
_____
_____

Has your child had remedial classes or tutoring? If so when, where, what kind:
_____
_____
Has your child ever been diagnosed with having a learning disability? _____
If yes, describe: _____
Was he/she placed in a special classroom or program? _____

Has your child had psychological or psychoeducational testing? _____
Has your child ever received any special services for speech, hearing or occupational therapy? _____ If yes, describe: _____

Has your child ever received any type of psychotherapy or counseling? _____
If yes, describe: _____

What is your child's attitude toward school? _____
What are your child's current grades like? _____
How do these grades compare with his/her grades one year ago? _____
Other comments about school: _____

Social Behavior & Activities

How does your child play and/or get along with other children at:
school_____
_____
neighborhood _____
_____
with siblings _____
_____

What things does your child like to do? _____
_____
_____

What things/activities present the greatest difficulty for your child?
_____
_____

_____

What are your concerns about your child's social functioning? _____
_____
_____

Family History

Please list all immediate family members (indicate if adopted, half or step-members)
Name Age Relationship Where living For siblings- School/Grade
_____
_____
_____
_____
_____
_____
_____

Previous Marriages: Date married Date terminated

Mother: _____
_____
Father: _____
_____

Are there any particular family stresses of which you are aware that may have a bearing on your child's problem? If yes, please describe: _____
_____
_____
_____

Who currently lives in the home?_____
_____
_____

Has your child ever been separated from the family? _____
If so, list age, duration and reason_____
_____
_____

If either parent has been married previously, and this child is not the natural child of one of the parents, please give information regarding the absent natural parent:

Name: _____ Age: _____
Where living? _____ Address: _____
_____

Phone: _____

Date of separation: _____

Date of divorce: _____ Reason for divorce: _____

Nature & frequency of this child's contacts with the absent natural parent:

_____

_____

What difficulties, if any, do any of the other children in the family have?

_____

_____

_____

Do you have any concerns regarding your family and it's current functioning?

_____

_____

_____

Family Medical History

Please indicate whether there are any relatives of your child (including parents, grandparents, aunts, uncles and cousins), who have (or have had in the past) the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic or recurrent illnesses or abnormalities such as birth defects, miscarriages, diabetes, convulsions or epilepsy (fits), mental or emotional disorders, substance abuse problems, slow development, mental retardation, school problems, cerebral palsy, muscular disorders, cancers, leukemia, thyroid disease, deafness or blindness, speech or language problems, reading or learning disabilities. (Please be as specific as possible, giving **relationship to the child, age of relative and problem**).

Mother_____

Mother's mother_____

Mother's father_____

Mother's brothers & sisters_____

Mother's maternal grandmother_____

Mother's maternal grandfather_____

Mother's paternal grandmother_____

Mother's paternal grandfather_____

Mother's aunts & uncles_____

Mother's cousins_____

Father_____

Father's mother_____

Father's father_____

Father's brothers & sisters_____
Father's maternal grandmother_____
Father's maternal grandfather_____
Father's paternal grandmother_____
Father's paternal grandfather_____
Father's aunts & uncles_____
Father's cousins_____

In the space provided below, please provide any additional information which you feel would be important for understanding your child and your particular concerns.