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Parent Questionnaire

PLEASE COMPLETE IN **BLACK INK**

Patient Name:	Date of Birth:
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Form Completed By: Mother ___ Father ___ Other: _____

Referring Physician: _____

Child Profile

What concerns do you have about your child: (please a brief summary of the main concerns)?

When were the problems first noticed? Have they progressed? How have they been handled so far?

What has your child been told about coming for this evaluation?

Past/Current Treatment History

Please list or describe any chronic medical problems (asthma, diabetes, developmental delays, etc).

Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements/vitamins)? No ___ Yes ___ If yes, specify:

Does your child have any allergies? No ___ Yes ___ If yes, specify:

Are your child's immunizations up to date? Yes ___ No ___ If no, please explain:

Has your child had vision and hearing screening performed either by your physician at the school? If yes, please specify when, by whom and results:

Has your child had previous neurological, developmental/behavioral, psychological, or psychiatric evaluations and/or treatment (e.g., medication, counseling, tutoring, speech, physical or occupational therapy, not described above and by whom?)

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Birth History

Was your child born two or more weeks before the "due date"? No ____ Yes ____

If yes, how many weeks early was your child born? _____ weeks early

How much did your child weigh at Birth _____

Biological Father's age at birth of your child ____ Biological Mother's age at birth of your child ____

Number of pregnancies prior to this child ____ Number of miscarriages prior to this child ____

Were there any problems during the pregnancy, labor/delivery or following the birth? No ____ Yes ____

If yes, please specify:

Was your child born by C-Section? No ____ Yes ____

If yes, please specify why:

Were any substances or medication used by the mother during the pregnancy? No ____ Yes ____

If yes, please specify (e.g., prescription medication, alcohol, tobacco, etc.)'

Developmental History:

(Please write in age. Ages in parenthesis are approximate normal limits.)

<p>Gross Motor:</p> <p>Rolled over (4-5 mos) _____</p> <p>Sat without support (6-7 mos) _____</p> <p>Walked alone (12-16 months) _____</p> <p>Runs (15-18 mos) _____</p> <p>Catches a ball (3 years) _____</p> <p>Hops on one foot 2-3 times (4 years) _____</p>	<p>Fine Motor:</p> <p>Copies circle (3 years) _____</p> <p>Copies Square (5 years) _____</p> <p>Adaptive /Self help:</p> <p>Drinks from a cup (12 – 15 mos) _____</p> <p>Uses a spoon (15-24 mos) _____</p> <p>Undresses completely (3 years) _____</p> <p>Dresses Completely (4 years) _____</p>
<p>Language Development:</p> <p>Babbles (6 mos) _____</p> <p>Understands "NO" (9-10 mos) _____</p> <p>3-5 word vocabulary (12 mos) _____</p> <p>Follows 1 step command with gestures (12 mos) _____</p> <p>Can point to several body parts (16-17 mos) _____</p> <p>2-word phrases (24 mos) _____</p> <p>Follows 2 step command (24 mos) _____</p> <p>3 word sentences (3 years) _____</p>	<p>Social/Emotional Development</p> <p>Temperament as a baby (e.g. easy, colicky):</p> <p>Shy with strangers (7-8 mos) _____</p> <p>Plays cooperatively with peers (4 yrs) _____</p> <p>Current temperament/mood (e.g. irritable, anxious, happy):</p>

Are there any current problems or concerns with development not mentioned already?

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Patient Review of Systems

Has your child had any problems mentioned below that you haven't already described?

	Y	N	Explain
Weight loss or gain			
Weakness			
Rash			
Itching			
Light or dark skin color changes			
Changes in hair growth or loss			
Headaches			
Double vision			
Neck stiffness or pain			
Chest pain			
Palpitations			
Fainting/passing out			
Heart murmurs			
Shortness of breath			
Wheezing			
Appetite changes			
Indigestion/reflux			
Nausea, vomiting or diarrhea			
Recent changes in bowel habits			
Change in urinary frequency			
Bed wetting			
Problems with menstruation			
Joint pain, swelling or redness			
Convulsions			
Staring spells			
Tremor			
Incoordination (ataxia, tremor)			
Anxiety / Depression			
Anemia			
Bleeding Tendency			
Previous Blood Transfusions			
Lymph node enlargement or tenderness			

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Family Medical History (other than patient)

Please include all pertinent **FAMILY history** for first and second-generation **FAMILY members**.

	Y	N	Family Member's relationship to child
Trouble learning to read			
Trouble with arithmetic			
Trouble with writing			
Attention Deficit/Hyperactivity disorder			
Other school problems			
Speech problems			
Language delay			
Behavior problem in childhood			
History of physical or emotional abuse			
Depression			
Anxiety/Phobia/panic disorders			
Other Mental illness			
Drinking problems			
Drug Abuse			
Seizures			
Mental Retardation			
Autism			
Headaches/Migraines			
Tourette Syndrome			
Neurologic Conditions			
Congenital Anomalies			
Diabetes			
High blood pressure			
Irregular Heartbeat or rhythm			
Heart attack before 40 years old			
Thyroid condition			
Deafness			
Blindness			
Any other disorders in the family			

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Social history

Child's School: _____ City: _____

Teacher's Name: _____ Grade: _____

Type of Classroom: Regular ____ RSP ____ Special Day Class ____

IEP: _____

This child is currently living with:

- Biological mother and biological father
- Biological mother
- Biological father
- Adoptive parents. Is your child aware that he/she is adopted? _____
- Foster parents
- Other (specify) _____

The biological parents of this child are currently:

- Married to each other (Years married: ____)
- Divorced from each other
- Separated from each other
- Never married to each other

Please list all people who are currently living in this child's household (name, age, and relationship to child):

Name	Age	Relationship

Other Concerns

Are you concerned about issues not covered in this questionnaire? Please describe:

Thank you for completing this questionnaire. It will be reviewed as a valuable first step in evaluating your child.