

**FOR STAFF USE**

First Appointment:

Consent To Treat signed:

## PARENT QUESTIONNAIRE

A thorough history is very important to accurate diagnosis and treatment of your child. Although some items may seem less relevant to current concerns, your answers will be helpful in understanding and evaluating your child appropriately. If there are answers you do not know or remember, simply noting that on the form will be sufficient. We look forward to working with you and your family.

### CHILD IDENTIFICATION

**Name** (Last, First, M.I.):

**Birth Date:**

**Age:**

**Gender:** \_\_\_ M \_\_\_ F

**School:**

**Grade:**

**Religion (Optional):**

**Race/Ethnicity (Optional):**

**Mother's name:**

**Father's name:**

**Address:**

**Home phone:**

**Parent work phone (please specify which parent):**

**With whom is the child currently living?**

### REFERRAL INFORMATION

**Referral source:**

**Phone #:**

**Referral address:**

**Do we have your permission to release or request information from the referring professional?** \_\_\_ Yes \_\_\_ No

### HISTORY AND PURPOSE OF CONSULTATION

**Please give a brief summary of the main problems.**

**Why did you seek the evaluation at this time?**

**What prior attempts to correct the problem(s) have been made? Please indicate prior psychiatric history, contact with other professionals, medications, types of treatment, etc.**


**What would you like us to do for your child, yourself, or your family?**


**MEDICAL HISTORY**

**Present height:**

**Present weight:**

**Please indicate any of the following that apply. Use the space below to describe.**

<input type="checkbox"/> History of head trauma	<input type="checkbox"/> Periods of spaciness	<input type="checkbox"/> Periods of confusion	<input type="checkbox"/> History of seizures or seizure-like activity
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**Describe current medical problems, including current medications.**


**Any Drug Allergies or intolerances (describe):**

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**Describe past medical problems, including past medications taken.**


List prior hospitalizations (date, place, reason, outcome):

Please indicate other doctors or clinics seen regularly.

List abnormal lab tests, X-rays, EEG, etc.

**FAMILY HISTORY**

Please describe your family structure—who lives in the current household with the child and relationship to the child.

Please describe any traumatic events that your child has experienced.

List any current factors that are a source of stress in the family.

**CHILD'S DEVELOPMENTAL HISTORY**

Prenatal History

<b>Parents' attitude toward the pregnancy:</b>	
<b>Conception:</b> ___ Easy ___ Difficult ___ Planned ___ Unplanned ___ In vitro ___ Artificial insemination	
<b>Pregnancy complications:</b> ___ Bleeding ___ Excessive vomiting ___ Infections ___ X-rays ___ Medication use ___ Smoking ___ Alcohol use ___ Street drug use ___ Other (describe):	
<b>Birth and Postnatal Period</b>	
<b>Birth weight:</b>	<b>Length:</b>
<b>Labor duration:</b>	
<b>Delivery type:</b> Vaginal ___ Yes ___ No <b>Cesarean</b> ___ Yes ___ No <b>Forceps</b> ___ Yes ___ No <b>Premature delivery</b> ___ Yes ___ No	
<b>Describe delivery problems.</b>	
<b>Apgar score</b> (if known): <b>1-minute score:</b> _____ <b>5-minute score:</b> _____ <b>Any jaundice?</b> ___ Yes ___ No	
<b>Describe any other complications.</b>	
<b>Length of newborn's hospital stay:</b>	
<b>Mother's Health after Delivery</b>	
<b>Post-delivery blues</b> ___ Yes ___ No	<b>Postpartum depression</b> ___ Yes ___ No
<b>How long did depression or blues last?</b>	
<b>Child Caretakers and Separations</b>	
<b>Primary caretaker for child in first year:</b>	
<b>Primary caretaker(s) after first year:</b>	
<b>Separations from mother and/or father?</b> ___ Yes ___ No	<b>At what age?</b> _____
<b>Duration:</b> _____	
<b>Describe child's reaction to separation.</b>	
<b>Feeding History</b>	
<b>Feeding method:</b> ___ Breast fed ___ Bottle fed	<b>Age at weaning:</b> _____
<b>List food allergies:</b>	
<b>Describe any current eating problems:</b>	
<b>Sleep History</b>	
<b>Sleep problems:</b> ___ Sleep-walking ___ Nightmares ___ Recurrent dreams ___ Gets up frequently ___ Trouble going to bed	
<b>Describe.</b>	
<b>Motor Development</b>	
Please write in the correct age; in parentheses are approximate normal limits.	
<b>Rolled over</b> (3-5 m):	<b>Crawled</b> (5-8 m):
<b>Sat without support</b> (5-7 m):	<b>Walked well</b> (11-16 m):

<b>Ran well</b> (2 yr):	<b>Rode tricycle</b> (3 yr):
<b>Threw ball overhand</b> (4 yr):	<b>Current level of activity:</b>
<b>Fine and gross motor coordination:</b>	
<b>Current level of activity:</b>	
<b>Coordination compared to peers:</b>	
<b>Language Development</b> Please write in the correct age; in parentheses are approximate normal limits.	
<b>Spoke many words besides "dada" or "mama"</b> (1yr):	
<b>Named several objects—ball, cup, etc.</b> (15 m):	
<b>Put 3 words together—subject, verb, object</b> (24 m):	
<b>Vocabulary:</b>	
<b>Articulation:</b>	<b>Comprehension:</b>
<b>Language development compared to peers:</b>	
<b>Any current problems:</b>	
<b>Social Development</b> Please write in the correct age; in parentheses are approximate normal limits.	
<b>Smiled</b> (2 m):	<b>Shy with strangers</b> (6-10 m):
<b>Separated from mother easily</b> (2-3 yr):	<b>Cooperative play with others</b> (4 yr):
<b>Quality of attachment to mother:</b>	
<b>Quality of attachment to father:</b>	
<b>Early peer interaction:</b>	
<b>Current peer interactions:</b>	
<b>Special interests:</b>	
<b>Relationships to family members:</b>	
<b>Hobbies/interests:</b>	
<b>Toilet Training</b> Please write in the correct age.	
<b>Bowel control during day reached at age:</b>	<b>Bowel control during night reached at age:</b>
<b>Bladder control during day reached at age:</b>	<b>Bladder control during day reached at age:</b>
<b>Methods used:</b>	
<b>Ease of training:</b>	
<b>Current function:</b>	
<b>Sexual Development</b>	
<b>Gender identification:</b>	

Any problems or concerns?

**Family Development**

Please include marriages, separations, divorces, deaths, traumatic events, losses, etc.

Current marital situation & satisfaction of parents:

Please tell us about any traumatic events that your family has experienced.

**Biological Mother's History**

Current age:

Education--highest grade completed:

Work outside of home:

Learning problems (specify):

Behavior problems (specify):

Marriages:

Medical problems:

Childhood atmosphere (family position, abuse, illnesses, etc.):

Has mother ever sought psychiatric treatment? \_\_\_ Yes \_\_\_ No If yes, for what purpose?

Mother's alcohol/drug use history:

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?

**Biological Father's History**

Current age:

Education--highest grade completed:

<b>Work outside of home:</b>	
<b>Learning problems</b> (specify):	
<b>Behavior problems</b> (specify):	
<b>Marriages:</b>	
<b>Medical problems:</b>	
<b>Childhood atmosphere</b> (family position, abuse, illnesses, etc.):	
<b>Has father ever sought psychiatric treatment?</b> ___ Yes ___ No <b>If yes, for what purpose?</b>	
<b>Father's alcohol/drug use history:</b>	
<b>Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?</b>	
<b>Step-Mother or Adoptive Mother's History, if applicable</b>	
<b>Current age:</b>	<b>Education--highest grade completed:</b>
<b>Work outside of home:</b>	
<b>Learning problems</b> (specify):	
<b>Behavior problems</b> (specify):	
<b>Marriages:</b>	
<b>Medical problems:</b>	
<b>Childhood atmosphere</b> (family position, abuse, illnesses, etc.):	
<b>Medical problems:</b>	
<b>Childhood atmosphere</b> (family position, abuse, illnesses, etc.):	
<b>Have step-/adoptive mother ever sought psychiatric treatment?</b> ___ Yes ___ No <b>If yes, for what purpose?</b>	
<b>Step-/Adoptive mother' alcohol/drug use history:</b>	
<b>Have any of step-/adoptive mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?</b>	
<b>Step-Father or Adoptive Father's History, if applicable</b>	
<b>Current age:</b>	<b>Education—highest grade completed:</b>
<b>Work outside of home:</b>	

<b>Learning problems</b> (specify):
<b>Behavior problems</b> (specify):
<b>Marriages:</b>
<b>Medical problems:</b>
<b>Childhood atmosphere</b> (family position, abuse, illnesses, etc.):
<b>Has step-/adoptive father ever sought psychiatric treatment:</b> ___ Yes ___ No <b>If yes, for what purpose?</b>
<b>Step-Adoptive father's alcohol/drug use history:</b>
<b>Have any of step-/adoptive father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?</b>

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**Signature**

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**Date**