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# PARENTS' QUESTIONNAIRE: HISTORY FORM

Please bring this completed form with you at the time of your next appointment
Please bring copies of relevant records (for example, recent report cards, standardized test scores, special education test reports, IEPs, etc.) and any previous psychological or psychiatric reports.

Child's Full Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Home Address: _____

City/State/Zip: _____Phone: _____

Child's School: _____

Address: _____ Grade: _____

Phone: _____ Fax: _____

**Special Education Placement:**

Has your child been placed in a special education program? ☐ No ☐ Yes
If yes, hours of service per day: _____ Type of class: _____
What grade did services begin? _____ What grade did services end? _____

**Previous Educational Diagnosis:**

Communication Disorder_____ Mental Retardation_____
Autism/Pervasive Developmental Disorder: _____ Other Health Impairment: _____
Attention-Deficit/Hyperactivity Disorder: _____ Emotional Disturbance: _____
Learning Disability: _____ Reading: _____ Math: _____ Writing: _____

**Source of Referral:**

Name: _____

Address: _____ Phone: _____

Fax No.: _____

Briefly state the main problems of your child and when the problems began:

_____

_____

_____

_____

Parent's Questionnaire Child's Name: _____

**PREGNANCY:**

Was the pregnancy planned? ☐ No ☐ Yes

Under Doctor's Care? ☐ No ☐ Yes

Complications (Specify trimester, duration): _____

Excessive vomiting _____

Hospitalization required _____

Specify weight loss, if any _____

Excessive staining/blood loss: _____ Time of gestation: _____

Threatened miscarriage: _____Time of gestation: _____

Treatment if known: _____

Premature rupture of membranes (> 24 hours): _____

Infection(s): _____ (specify) _____

Toxemia: _____ Operation(s): _____ (specify) _____

Exposure to toxic or industrial chemicals: _____

Other illness(es) or injury (specify):_____

Unusual weight gain: ☐ No ☐ Yes

Smoking during pregnancy: ☐ No ☐ Yes Cigarettes per day: _____

Alcoholic consumption during pregnancy: _____ Describe if beyond an occasional drink: _____

Other drugs used: _____

Medications taken during pregnancy (include over the counter drugs):

Prescription: ☐ No ☐ Yes

Type_____ Frequency _____

X-ray studies during pregnancy (include dental, note if shield was used):

_____

Duration of pregnancy (weeks): _____

**DELIVERY:**

Type of labor: Spontaneous _____ Augmented with Pitocin _____

Induced (specify pitocin or rupture of membranes) _____

Duration (hours) _____ Type of delivery: normal _____ breech _____

Forceps used: ☐ No ☐ Yes

Caesarean _____ If C-Section, note indications: _____

_____

Medications for labor/delivery _____

Analgesia _____ Anesthesia_ _____

Complications: Cord around neck _____ Hemorrhage _____

Infant injured during delivery _____ Other _____

Birth weight _____lb, ____oz APGAR Scores/ _____ Fetal Distress _____

Need for resuscitation _____ If so, how? _____

**POST DELIVERY PERIOD:**

Jaundice _____ If yes: How high was bilirubin, if known _____

How treated: Lights _____ Transfusion _____ Phenobarbital _____

Etiology, if known _____

Respiration (turned blue) _____ supplemental oxygen _____

Infection (specify) _____

Seizures _____ IVs _____ Birth anomalies _____ Other _____

Number of days infant was in the hospital after delivery _____

Number of days mother was in the hospital after delivery _____

Parent's Questionnaire Child's Name: _____

**INFANCY-TODDLER PERIOD:**

Were any of the following present – to a significant degree – during the first few years of life? If so, describe:

Did not enjoy cuddling _____

Was not calmed down by being held or stroked _____

Colic _____ Duration _____

Time of day _____ Excessive restlessness _____

Diminished sleep _____ Frequent head banging _____

Constantly into everything _____

Excessive number of accidents compared to other children _____

Unusual behavior or development during the years 1-5 _____

_____

How fed _____ Weight gain _____

Feeding problems _____

Disposition _____

Was your baby "floppy" or "stiff" _____

**DEVELOPMENTAL MILESTONES:**

If you can recall, record the age (month/year) at which your child reached the following developmental milestones. If you cannot recall, check item at right.

| | | **I cannot recall exactly, but it occurred about**: | | |
|---|---|---|---|---|
| | Age | Early | Normal | Late |
| Smiled | ____ | _____ | _____ | _____ |
| Sat without support | ____ | _____ | _____ | _____ |
| Crawled | ____ | _____ | _____ | _____ |
| Turned front to back | ____ | _____ | _____ | _____ |
| Turned back to front | ____ | _____ | _____ | _____ |
| Stood without support | ____ | _____ | _____ | _____ |
| Walked without assistance | ____ | _____ | _____ | _____ |
| Spoke first words | ____ | _____ | _____ | _____ |
| Said phrases | ____ | _____ | _____ | _____ |
| Bladder trained, day | ____ | _____ | _____ | _____ |
| Bladder trained, night | ____ | _____ | _____ | _____ |
| Bowel trained, day | ____ | _____ | _____ | _____ |
| Rode tricycle | ____ | _____ | _____ | _____ |
| Rode bicycle (w/o training wheels) | ____ | _____ | _____ | _____ |
| Buttoned clothing | ____ | _____ | _____ | _____ |
| Tied shoelaces | ____ | _____ | _____ | _____ |
| Named colors | ____ | _____ | _____ | _____ |
| Said alphabet in order | ____ | _____ | _____ | _____ |
| Began to read | ____ | _____ | _____ | _____ |

Did bed-wetting occur after toilet training? ☐ No ☐ Yes If yes, what age __

Did soiling occur after toilet training? ☐ No ☐ Yes If yes, what age __

Was there a medical reason for wetting or soiling? ☐ No ☐ Yes If yes, describe: __

_____

Parent's Questionnaire Child's Name: _____

**MEDICAL HISTORY:**

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe any complications) _____
Cuts and stitches _____ How many times _____
Broken bones _____ How many times _____
Operations _____
Hospitalizations for illness _____
_____
Head injuries _____
Convulsions _____ with fever _____ without fever _____
Coma _____
Persistent high fevers _____
Eye problems _____ Vision problems _____
Ear problems_____ Average # of ear infections per year _____Ear tubes placed _____
Tonsils out _____ Adenoids out _____Poisoning _____
Sleep problems _____Eating problems _____
Eating disorder_____ Physical abuse _____
Sexual abuse _____
Unclear speech _____
Overweight _____

**PRESENT MEDICAL STATUS:**

Date of last medical examination:_____ Results:_____
Height _____ Weight _____
Present illnesses for which the child is being treated: _____
_____

Hearing and Vision

Has your child been evaluated for:

| | | | | |
|---|---|---|---|---|
| Hearing | ☐ No | ☐ Yes | If yes, date _____ | Results _____ |
| Vision | ☐ No | ☐ Yes | If yes, date: _____ | Results _____ |

**Medication History**:

Medication: Dosage: Prescribing Doctor:
_____ _____ _____

Reason prescribed: _____

Child's Response: _____

Start Date: _____ Stop Date: _____

Medication: Dose: Prescribing Doctor:
_____ _____ _____

Reason prescribed: _____

Child's Response: _____

Start Date: _____ Stop Date: _____

Parent's Questionnaire Child's Name: _____

**COORDINATION:**

Rate your child on the following skills:

| | Good | Average | Poor |
|---|---|---|---|
| Walking | _____ | _____ | _____ |
| Running | _____ | _____ | _____ |
| Skipping | _____ | _____ | _____ |
| Throwing | _____ | _____ | _____ |
| Catching | _____ | _____ | _____ |
| Kicking | _____ | _____ | _____ |
| Shoelace tying | _____ | _____ | _____ |
| Buttoning | _____ | _____ | _____ |
| Writing | _____ | _____ | _____ |
| Athletic abilities | _____ | _____ | _____ |
| Bike riding | _____ | _____ | _____ |

Which hand does this child use for writing or drawing? ☐ Right ☐ Left

Eating? ☐ Right ☐ Left

Throwing? ☐ Right ☐ Left

**COMPREHENSION AND UNDERSTANDING:**

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not? _____

How would you rate your child's overall level of intelligence compared to other children?

Below average _____ Above average _____ Average _____

What is the primary language spoken at home: _____ Other languages your child speaks or hears at home: _____

**SCHOOL:**

Rate your child's school experiences related to academic learning(grades):

| | Good | Average | Poor |
|---|---|---|---|
| Nursery school | _____ | _____ | _____ |
| Kindergarten | _____ | _____ | _____ |
| Current grade | _____ | _____ | _____ |

Did your child attend preschool? ☐ No ☐ Yes

At what age did your child enter Kindergarten _____ To the best of your knowledge, at what grade level is your child functioning: Reading _____ Spelling_____ Arithmetic_____

Has your child ever had to repeat a grade? _____ If so, when? _____

Has your child skipped a grade? _____ If so, when _____

Present class placement:

Regular class _____ Special class _____ (if so, specify) _____

_____

Kinds of special counseling or remedial work your child has received:_____

_____

Describe briefly any academic school problems _____

_____

Describe your child's academic strengths at school _____

Parent's Questionnaire Child's Name: _____

_____

_____

Has your child ever been tested for special education? ☐ No ☐ Yes

If yes, previous testing results (if known) _____

Results of standardized testing (if known)_____

Current GPA_____ What level of school do you expect your child to complete?

☐ High School ☐ College ☐ Technical/Vocational school

☐ Graduate School (e.g. Law, Medical, or other advanced degree).

Schools Attended:

| Name of School: | Grades Attended: | Reason Changed School |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Rate your child's school experiences related to behavior:

| | Good | Average | Poor |
|---|---|---|---|
| Nursery school | _____ | _____ | _____ |
| Kindergarten | _____ | _____ | _____ |
| Current grade | _____ | _____ | _____ |

Does your child's teacher describe any of the following as significant classroom problems:

Does not sit still in his or her seat _____

Frequently gets up and walks around the classroom _____

Shouts out. Does not wait to be called on _____

Will not wait his or her turn _____

Does not cooperate well in group activities _____

Typically does better in a one to one relationship _____

Does not respect the rights of others _____

Does not pay attention during storytelling or show and tell _____

Describe briefly any other classroom behavioral problems _____

_____

_____

Does your child like school? ☐ No ☐ Yes

Is your child absent frequently? ☐ No ☐ Yes If yes, how often? _____

**PEER RELATIONSHIPS:**

Does your child fight frequently with peers? ☐ No ☐ Yes

Does your child make friends easily? ☐ No ☐ Yes

Does your child play with children primarily his or her own age? _____

younger? _____ older? _____ Prefers to play alone? ☐ No ☐ Yes

Describe briefly any problems your child may have with peers: (e.g.: fights, cheats, excessively shy)_____

_____

Describe briefly any strengths your child may have with peers: (e.g. initiates play, peacemaker)

_____

Parent's Questionnaire Child's Name: _____

_____

What role does the child take in peer games? (leader, aggressor, boss, follower, etc.)

_____

**HOME BEHAVIOR:**

Describe briefly the positive behaviors your child shows at home: _____

_____

_____

Describe what you find most difficult about raising your child:_____

_____

Many children exhibit, to some degree, some of the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children at his or her own age.

Hyperactivity (high activity level) _____
Poor attention span _____
Impulsivity (poor self-control) _____
Temper outbursts _____
Low frustration threshold _____
Overreacts to problems_____
Seems uncomfortable meeting new people _____
Seems unhappy most of the time _____
Sloppy table manners _____
Interrupts frequently _____
Doesn't listen _____
Sudden outbursts of physical abuse of other children _____
Acts like he or she is driven by a motor _____
Wears out shoes more frequently than other siblings _____
Heedless of danger _____
Excessive number of accidents _____
Doesn't learn from experience _____
Poor memory _____
More active than siblings _____
A "different child" _____
Grinds teeth _____ Distractible _____
Tantrums _____ Truancy _____
Wandering/Running away _____
Fire starting _____ Match play _____
Pica (eats non-food) _____
Wetting _____ Fecal soiling _____
Stealing _____ Destructive _____
Lying _____ Cruelty to animals _____
Sleeping problems _____
Rocking _____ Thumb sucking _____
Perseverative behavior _____ Self-injury _____
Talks about suicide _____
Has fears _____ If yes, describe _____
_____

Types of discipline you use with your child and how he or she responds:

<u>Types of disciplined used</u> <u>Child's response</u>

Parent's Questionnaire Child's Name: _____

_____ _____

_____ _____

_____ _____

Do the caregivers agree on how to discipline? ☐ No ☐ Yes

**INTERESTS AND ACCOMPLISHMENTS:**

What are your child's main hobbies and interests? _____

_____

What are your child's areas of greatest accomplishment? _____

_____

What sports does your child enjoy?_____

_____

What does your child enjoy doing the most? _____

_____

What does your child dislike doing the most? _____

_____

Has your child's interest in participating in activities gone down recently? ☐ No ☐ Yes

If yes, describe _____

**FAMILY HISTORY:**

Are child's parents related in any way other than by marriage? No _____ Yes _____

If yes, how? _____

Family Residence

☐ Apartment ☐ Single Home ☐ Other Time at current address? _____

**Family History–Mother**

Age _____ Age at time of pregnancy with patient _____

Occupation _____

School: Highest grade completed _____

Learning problems? ☐ No ☐ Yes If yes, describe _____

Behavior problems? ☐ No ☐ Yes If yes, please describe _____

Medical problems _____

Reproductive history:

Number of previous pregnancies _____

Number of live births _____

Number of spontaneous abortions _____

Number of therapeutic abortions _____

Have any of your blood relatives experienced problems in learning or development? ☐ No ☐ Yes

If so, describe _____

**Family History–Father**

Parent's Questionnaire Child's Name: _____

Age _____ Age at time of pregnancy with patient _____

Occupation _____

School: Highest grade completed _____

Learning problems? ☐ No ☐ Yes If yes, describe _____

Behavior problems? ☐ No ☐ Yes If yes, please describe _____

Medical problems _____

Have any of your blood relatives experienced problems in learning or development? ☐ No ☐ Yes

If so, describe _____

Does this child have any other parent(s) or step parent(s)? ☐ No ☐ Yes

If yes, please provide the following.

Name _____ Relationship to child _____

Home Phone _____ Address _____

**SIBLINGS**

| | Name | Sex | Age | Medical, social, or school problems |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

How does your child get along with brother(s) and sister(s)? _____

**NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED**

(including family doctor)

| | Name | Address | Phone |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

What are your expectations for your child's assessment, treatment, and ongoing care?

_____

_____

_____

**OTHER EXTENDED FAMILY MEDICAL HISTORY:**

| | Difficulty | Who | Relationship |
|---|---|---|---|
| _____ | Seizures | | |
| _____ | Mental Retardation | | |

| | Difficulty | Who | Relationship |
|---|---|---|---|

Parent's Questionnaire Child's Name: _____

_____ Attention Deficit Disorder _____
_____ Communication Disorder/Autism _____
_____ Depression _____
_____ Schizophrenia _____
_____ Drug Abuse _____
_____ Alcoholism _____
_____ Thyroid Problems _____
_____ Genetic Metabolic Disorders _____
_____ Anxiety _____

**SUBSTANCE ABUSE:**

Do you have any reason to suspect substance use or abuse by your child? ☐ No ☐ Yes
Have you ever felt your child ought to cut down on his/her drinking or drug use? _____
Has your child ever been annoyed by someone criticizing his/her drinking or drug use? _____
Has your child ever felt bad or guilty about drinking or drug use? _____
Has your child ever had a drink or used drugs first thing in the morning to steady his/her nerves or get rid of a hangover? _____

**PRESENT PLACEMENT OF CHILD:**

(Please check in appropriate bracket)

| | Adult with whom child is living. | Non-residential adults involved with child. |
|---|---|---|
| Natural Mother | ( ) | ( ) |
| Natural Father | ( ) | ( ) |
| Stepmother | ( ) | ( ) |
| Stepfather | ( ) | ( ) |
| Adoptive Mother | ( ) | ( ) |
| Adoptive Father | ( ) | ( ) |
| Foster Mother | ( ) | ( ) |
| Foster Father | ( ) | ( ) |
| Other (specify)_____ | ( ) | ( ) |

Has the child ever experienced parent separation, divorce, or death? _____
If so, child's age at time(s) of divorce(s) or death. _____, what year?_____
Please describe the circumstances._____
_____
_____
If parents, are separated or divorced, who has legal custody?_____
How often does the other parent see the child?_____
Number of times child has moved _____

**PARENTS**

**Mother** _____ Stepmother? ☐ No ☐ Yes
Employer _____ Business phone _____
Business name _____
Business address _____
How long with present employer? _____

Parent's Questionnaire Child's Name: _____

**Father** _____ Stepfather ? ☐ No ☐ Yes

_____

Employer _____ Business phone _____

Business name _____

Business address _____

How long with present employer? _____

**ADDITIONAL REMARKS:**

Please use the bottom of this page to write any additional remarks you wish to make regarding your child's difficulties.

Form completed by: Name: _____

Relationship to child: _____

Date: _____