PARENT QUESTIONNAIRE (BEHAVIORAL HEALTH)

Child's Name: _____ Nickname: _____
Grade ____ School _____ County: _____
Person Completing Form: _____ Relation to child: _____
Referring Physician / Practice: _____

CONCERNS: (Check and explain any areas of difficulty or concern you have about your child):

___ Learning

___ Behavior

___ Social Skills

___ Emotional Development

___ Play

___ Homework

___ Attention

___ Sleep

___ Toileting

Please describe purpose of today's visit and specific questions you would like answered: _____
_____
_____

When did you first become concerned about your child's problems? Please explain _____
_____

HOME:
How does your child routinely behave in the following areas? (Check all that apply)

Social Interactions: ___cooperative, ___seeks out peers, ___plays well with others, ___prefers independent play, ___ has difficulty making friends but wants to, ___bossy, ___aggressive. Explain _____

Daily Routines: ___follows routines easily, ___understands routines but needs guidance, ___does not understand routines, ___strong preference for routines, ___ becomes upset when routines are interrupted, ___ has difficulty making transitions during the day.
Explain _____

Behavior: ___ well-behaved, ___ challenging/needs support, ___extremely difficult to manage. Explain _____

Sensitivities: ___ lights, ___sounds, ___textures / tags, ___touch, ___ food tastes/textures.
Explain: _____

Sleep: ___sleeps well, ___difficulty falling asleep, ___frequent night awakenings, ___resists bedtime, ___nighttime bed wetting, ___ snores, ____ restless, active sleeper
Describe bedtime routine: _____
How many hours per night does your child sleep on average? ____ Does s/he sleep alone? _____
Explain _____
Media (e.g.,TV, tablet) in room / are there limits on use?: Explain _____

Preferred play activities / enjoyment preferences: _____
Estimated media time each day: _____

SCHOOL INFORMATION / INTERVENTIONS: (Please answer or check where appropriate)
Summarize your child's grades: _____
Does teacher have concerns? ___ no ___ yes Explain: _____
_____
Has your child ever failed an EOG: ___ no ___ yes Explain: _____
Has your child ever been repeated a grade: ___ no ___ yes Explain: _____

Current services:

Educational supports **currently** receiving: ___ none, ___ IEP, ___504 Plan, ___ tiered classroom intervention, ___tutoring, ___ other (explain _____)

School therapies: ___none, ___ speech/language therapy, ___occupational therapy (OT), ___ physical therapy (PT), ___ developmental therapy, ____other (explain _____)

Private therapies: ___none, ___ speech/language therapy, ___ OT, ___ PT, __ developmental therapy, ___ psychologist / counselor, ___ other (explain _____)

Past services no longer receiving:
___none, ___ speech/language therapy, ___ OT, ___ PT, ___ IEP, ___ Early Intervention, ____other (explain _____)

Previous testing:
Has your child had any previous testing completed at school or by private therapists or clinicians to address concerns with his/her learning, development, language, behavior or social functioning?
___ no, ___ yes If yes, please summarize _____
_____
_____

HISTORY:

Birth and Early Development:
Term birth ____ yes ____ no Explain: _____
Delivery _____ vaginal ____ cesarean section
Complications during pregnancy or birth? ____ yes ____ no. Explain _____
Went home after routine newborn stay? ___yes ___no. Explain _____
Went to NICU after birth? ___yes ___no If yes, how long in NICU? _____

Check any issues mother experienced during pregnancy? ___ none, ___hypertension, ___gestational diabetes, ___iron deficiency anemia, ___exposure to tobacco smoke, ___exposure to drugs or medications, ___significant social stressors , ___ alcohol use

Early Development (please estimate age at which your child did the following):

- Social: Smiled _____ Pointed to show you things _____ Separation Anxiety _____
- Motor: Crawled _____ Walked _____
- Language: Pointed to request _____ Used Words _____ Used Phrases _____

Did your child respond turn to his/her name by 1st birthday? ___ yes, ____no
Did child imitate actions (wave bye-bye) and use toys purposefully by 18 months? __yes, __no
Has your child ever lost skills s/he once had ? ____ yes, ___ no Explain _____

Medical History: (please list or explain all that applies to your child)
Current medical conditions or diagnoses and treatments: _____
_____
Current medications: _____
Allergy to any medications? ____ yes, ___ no Explain _____
Past medical conditions and treatments: _____
_____
Past hospitalizations or surgeries? _____
Does your child wear glasses? ____ yes, ____ no. When was last eye exam? _____
Does s/he have history of ear infections? ___ yes, ___ no. When was last hearing exam? _____
Has your child been diagnosed with ADHD? ___ yes, ___ no When?
_____
Has your child ever been in treatment with a counselor or therapist? ___ yes, ____ no
Explain _____
Is your child followed by any medical specialists? ___yes, ___ no Explain _____
_____
If your child has any upcoming medical tests or procedures, please explain: _____
_____

FAMILY INFORMATION:

Please indicate who lives in child's home: (e.g., mother, father, brother, grandmother, and etc):
_____

If child has lived with someone other than above noted parent or caregiver, please explain:
_____

Please check if there is a known family history of: ____ learning problems, ____dyslexia, ____ADHD, ____anxiety, ___ depression, ___bipolar disorder, ___autism spectrum disorder, ____schizophrenia, ___ other (explain _____)

PERSONAL TRAITS:

How would you describe your child to others?_____
What is your favorite thing about your child?_____

Please list any additional comments you would like to add below:

Thanks so much for your time in completing this! I look forward to meeting with you.