New Beginnings Neuropsychology, PLLC

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Parent Questionnaire for Children and Adolescents

Please answer the following questions carefully and completely. Your answers will help us greatly in our understanding of your child. The questionnaire will be reviewed with you, so it will be possible to discuss your answers.

Child's Name: _____ Date _____
Nickname _____ Age: _____ Date of Birth: _____
Name of legal guardians: _____
Person completing form: _____ Relation to child: _____
Day phone: _____ Cell phone: _____
Mailing Address: _____
Email: _____

Reason for Referral

Please list, in order of urgency, the problem(s) your child is experiencing:

A. _____

B. _____

C. _____

D. _____

E. _____

Family Situation

Who is the child currently living with? *Please Circle*

both natural parents	natural mother	grandparents
stepmother / stepfather	natural father	other (*describe)*
adoptive parents	foster parents	

Siblings (gender and age): _____

Pregnancy

1. Age of parents at time of child's birth: mother _____ father _____

2. While mother was pregnant, did she have any of the following difficulties?

_____ spotting or bleeding

_____ frequent nausea or vomiting

_____ swelling or toxemia

_____ preeclampsia/eclampsia

_____ high blood pressure

_____ clotting disorder

_____ thyroid problems

_____ diabetes

_____ kidney disease

_____ pneumonia

_____ headaches

_____ flu, infections, high fever

_____ hospitalization prior to delivery

_____ very overweight

_____ very underweight

_____ measles/rubella

_____ venereal disease

_____ heart trouble

_____ nervous

_____ worried

_____ depressed

_____ family problems

_____ marital problems

_____ financial problems

_____ accidents/ injuries_____

_____ surgeries_____

_____ medications _____

_____ alcohol intake _____

_____ drug use _____

_____ exposure to toxic chemicals or substances _____

_____ stressful events for one or both parents _____

_____ other social problems _____

Delivery

1. Was baby full term? _____ If not, how many weeks premature? _____

2. Birth weight _____

3. Length of hospital stay for mother? _____ Length of stay for child? _____

Was any of the following present during or soon after delivery?

_____ mother was put to sleep

_____ C-section performed

_____ instruments used to deliver

_____ RH factor present

_____ breech birth or presentation

_____ born with cord around neck

_____ baby was blue

_____ baby was placed in an incubator. If yes, how long?_____

_____ other medical problems at birth (*describe)* _____

_____

_____ baby was jaundiced (yellow)

_____ baby aspirated meconium (breathed waste)

_____ baby needed blood

_____ baby needed oxygen

_____ baby had trouble sucking

_____ baby had trouble keeping food down

4. Is there a family history of the following: (*please indicate who – parent, sibling, maternal grandfather, etc.)*

Autism

Anxiety

Learning disabilities/Dyslexia

Intellectual disability (MR)

Bipolar Disorder

Congenital or Chromosomal Abnormalities

Depression

Schizophrenia

ADD/ADHD

Speech or language delay

Other _____

Developmental History

1. Do you have any concerns with your child's early development in areas of:

   motor development: _____

   language development: _____

   social development: _____

3. Estimate the age at which the following occurred:

Age (in months)	Age (in months)
_____ smiled	_____ spoke first words
_____ held head up	_____ spoke in phrases
_____ sat unsupported	_____ spoke in sentences
_____ crawled	_____ toilet-trained- bladder
_____ took first steps	_____ toilet-trained- bowel
_____ walked alone	_____ dressed self

Medical Information

1. Has your child had any serious illnesses, injuries, or hospitalizations? _____

If yes, please describe:

Age	Description

2. Please write the ages (in years) that your child had any of the following illnesses from beginning of the illness to end:

Ages	Ages	Ages
_____ allergies	_____ head injuries	_____ pneumonia
_____ asthma	_____ heart trouble	_____ prolonged colic
_____ blood transfusion	_____ high fevers	_____ tonsillitis/strep
_____ seizures	_____ major fractures	_____ tics, twitching
_____ diabetes	_____ menstrual problems	_____ frequent ear infections
_____ meningitis	_____ loss of consciousness	_____ PE (ear) tubes
_____ tonsillectomy	_____ adenoidectomy	_____ Other:

3. The physician who referred my child for evaluation is _____

4. My child's present medications are _____

   Previous medications? _____

5. Please list therapies currently receiving _____

_____

6. Results of most recent exam:

   Vision: normal corrected with glasses / contacts / vision therapy

   Hearing: normal corrected with hearing aids / PE tubes

7. Has your child had an MRI done in the past?_____

8. Has your child had any chromosomal testing? _____

   If so, what were the results? _____

9. Please describe your child's present eating habits. (Note any problems in these areas).

_____

_____

10. Does your child eat a variety of foods? _____

Is your child on any special Diets? _____

Does your child have any known food allergies? _____

Does your child have irregular bowel patterns or difficulty with constipation or reflux?

_____

Does your child have any weight concerns (over or under weight)? _____

_____

11. Please describe your child's present sleep habits. (Please note any problems in going to sleep, sleeping alone, night awakenings, length of sleep, nightmares, sleep walking, etc.) _____

_____

_____

Usual bed time _____ Wake time _____ Naps? _____

Please describe the current sleeping arrangements for you child. _____

_____

School History

1. Current grade ____ School _____ District _____

Current teacher(s)_____

2. Did your child attend daycare? _____ How old was your child when he or she started? _____ Describe the setting and the child's reaction to it. _____

_____

3. Please list below the daycare centers, preschools and schools attended:

School	Location (City, State)	Ages/ Grades

4. Has your child ever repeated a grade? _____ If yes, what grade and what was the reason? _____

_____

5. Please write the grade in which your child may have received any of the following services **in the school setting**:

_____ Head Start

_____ PPCD

_____ Section 504 plan

_____ Early Reading Program (Title I)

_____ Speech Therapy

_____ Physical Therapy

_____ Occupational Therapy

_____ School Counselor

_____ Resource Room

_____ Self-Contained Classroom

_____ Special Education Services

_____ Inclusion Services

*If your child is in **special education**, please circle their current eligibility category*

Speech Impairment

Autism

Learning Disability

Intellectual Disability

Emotionally Disturbed

Traumatic Brain Injury

Other Health Impaired

Other: _____

Please list any academic subjects that were addressed with these services _____

_____

_____

_____

_____

6. Please rate your child's current school performance (*circle one)*

Reading:	Failing	Below Average	Average	Above Average
Written Expression:	Failing	Below Average	Average	Above Average
Math:	Failing	Below Average	Average	Above Average
Spelling:	Failing	Below Average	Average	Above Average
Handwriting:	No Concern	Poor spacing	Poor letter formation	
	Letter reversals	Immature grip		

7. Describe any academic or school problems your child is currently experiencing.

_____

_____

8. Has your child had any previous testing? If so, by whom and when? _____

_____

_____

9. Does your child have any previous diagnoses? If so, please explain. _____

_____

_____

Social Functioning

1. **Compared to other children** of your child's age, how well does your child:

		Circle one	
Get along with siblings:	Worse	Same	Better
Get along with other children	Worse	Same	Better
Behave with his/her parents	Worse	Same	Better
Play by self	Worse	Same	Better
Work by self	Worse	Same	Better
Behave in public (restaurants, etc)	Worse	Same	Better
Behave with babysitters	Worse	Same	Better
Behave at daycare or school	Worse	Same	Better

2. How does your child relate to others? *(Please checkmark next to words that describe your child)*

_____ affectionate	_____ fun-loving	_____ self-conscious
_____ annoys	_____ generous	_____ selfish
_____ cruel	_____ impulsive	_____ serious
_____ curious	_____ jealous	_____ shy
_____ easily angered	_____ lazy	_____ show-off
_____ easily embarrassed	_____ lonely	_____ suspicious
_____ easily mislead	_____ mean	_____ teases
_____ easily upset	_____ no friends	_____ tense
_____ fearful	_____ quiet	_____ trusting
_____ fights	_____ resentful	_____ withdraws
_____ friendly	_____ rough	

3. How does your child relate to his/ her parents? *(Please checkmark next to words that describe your child)*

_____ afraid	_____ easily controlled	_____ talks back
_____ angry	_____ helpful	_____ tells lies
_____ asks for help	_____ hits	_____temper tantrums
_____ bosses	_____ ignores	_____ tries to please
_____ comforts	_____ obedient	_____ uncontrollable
_____ cooperative	_____ pouts	_____uncooperative
_____ cries	_____ seeks attention	_____ withdraws
_____ disobedient	_____ shares feelings	_____ yells

4. Please list your child's special strengths, talents, and abilities: _____

_____

_____

5. Please describe any unusually positive or negative relationships this child has with important people in his/ her life: _____

_____

_____

6. Please provide any additional information that will assist the examiner in obtaining relevant information regarding your child's difficulties _____

_____

_____

_____