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PARENT QUESTIONNAIRE – YOUNG CHILDREN

Today's Date: _____ Name of person completing this form: _____

Child's Full Name: _____
First *Middle* *Last*

Child's Date of Birth: _____/_____/_____ Age: _____ Child's Gender: Male Female

Current Grade in School: _____ Name of School: _____

This is a private / public / charter /home school. School District: _____

Child's Address: _____
Street *Apt. Number*

_____
City *State* *County* *Zip Code* *Home Phone Number*

My child has lived at the above address for _____ years / months (circle one).

Father's Name: _____ Age: _____ Cell Phone: (_____)_____
First *Last*

Father's Address *(if different from above)*:_____
Street *Apt. #*

_____
City *State* *County* *Zip Code*

Father's employer: _____
Company *City*

_____(_____)_____
Job Title *Work Phone Number*

Mother's Name: _____ Age: _____ Cell Phone: (_____)_____
First *Last*

Mother's Address *(if different from above)*:_____
Street *Apt. #*

_____
City *State* *County* *Zip Code*

Mother's employer: _____
Company *City*

_____(_____)_____
Job Title *Work Phone Number*

FAMILY CONSTELLATION:

Who is the managing conservator of the child? Mom & Dad Mother Father Other_____

If there has been a court decision creating or affecting the legal custody (managing conservatorship) of the child, please indicate: Sole Managing Conservator Joint Managing Conservator

Biological parents are: Married Separated Divorced

Single Parent Mother Deceased Father Deceased

Date Married: _____ Date Separated: _____ Date Divorced: _____

Date Mother Re-married: _____ Date Father Re-married: _____

If child is adopted, list age of child at time of adoption: _____

Child resides primarily with (circle all that apply):

Mother Father Step-mother Step-father Grandparent(s) Other_____

If parents are separated or divorced, please list visitation arrangement. _____

_____

Name(s) and age(s) of child's brother(s), *please indicate if half- or step-brother(s):*

_____

Name(s) and age(s) of child's sister(s), *please indicate if half- or step-sister(s):*

_____

List name(s) of sibling(s) who do not reside in the home: _____

Others living in the home: _____

Mother's highest level of education completed: _____

Father's highest level of education completed: _____

(if applicable)

Step-mother's Name: _____ Age: _____ Highest level of education completed:_____

Present occupation: _____ Employer: _____

Step-father's Name: _____ Age: _____ Highest level of education completed:_____

Present occupation: _____ Employer: _____

Primary language spoken in the child's home: English Spanish Other_____

To what extent do you find interacting with this child a pleasant experience? (place X on line below)

Very pleasant ----------Very unpleasant

FAMILY MEDICAL HISTORY: Please list family members, other than the person being evaluated or treated, who have experienced the following problems. Use additional space on back of page, if needed.

Problem/Condition	Relationship of family member to this child (e.g., maternal aunt, paternal grandfather)
Problems learning to read	
Problems learning to spell	
Problems learning to write	
Problems learning mathematics	
Problems focusing/organizing as a child	
Attention-Deficit/Hyperactivity Disorder	
Oral Language Disorder	
Speech articulation problem/disorder	
Mental Retardation	
Slow Development	
Seizures / Epilepsy	
Tics / Tourette's Syndrome	
Autism/Pervasive Developmental Disorder	
Asperger's Syndrome/Disorder	
Endocrine Problems	
Musculoskeletal Problems	
Hearing Problems	
Vision Problems	
Drinking Problem/Drug Abuse	
Depression, Bipolar Disorder	
Anxiety Problems/Disorder	
Other Psychological Problems/Disorders Specify: _____	
Behavior problems in childhood/adolescence	
Criminal Record	
Early death, Other: _____	

Please list significant family stressors (i.e, parental separation, divorce, death in family, parental unemployment, financial hardships) that are current and/or that have occurred over the past two years:

_____

_____

REASON FOR REFERRAL:

Because you know your child the best, your input is invaluable to his/her evaluation/treatment. Thank you for taking the time to be specific. Dr. McLane evaluates and treats children of different ages and for a variety of problems, so some questions may not be as relevant for your child as others.

How did you hear about Dr. McLane? _____

Who recommended this appointment and why? _____

_____

What do you want to know from this evaluation/treatment?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

What are your child's strengths, special qualities, and talents? *(Circle all that apply)*

Well-liked	Learns quickly	Regulates sad, angry feelings	Optimistic/resilient
Social skills	Memory	Early literacy/math skills	Positive attitude
Making/keeping friends	Self-confident	Thinks before acting	Self-directed
Cooperative	Arts/crafts	Planning/organizing	Adjusts well to changes
Motor coordination	Drawing	Stays on task	
Listening skills		Follows oral directions	
Expressing his/her ideas when speaking		Processes info. rapidly	
		Creative	

Other: _____

_____

_____

_____

_____

_____

_____

What are your child's weaknesses or problem areas? *(Circle all that apply)*

Early literacy/math skills	Planning ahead	Low self-esteem	Needs extra help to complete daily tasks
Learning/processing slowly	Handwriting	Social skills	
Remembering information	Drawing, crafts	Make/keep friends	Trouble following routines or making transitions
Focusing attention	Puzzles	Teased/bullies others	
Acting before thinking	Logical thinking	Completing tasks slowly	Stubborn
Easily overwhelmed	Temper outbursts	Making eye contact	Too self-centered
Following oral directions	Worried/fearful	Repetitive thoughts/behaviors	
Listening skills	Sad/pessimistic	Little interest in other people	
Expressing his/her ideas when speaking	Disruptive	Motor coordination/sports	
	Uncooperative	Negative attitude	

Other _____

_____

When did you first become concerned about these weaknesses or problem areas? _____

_____

_____

_____

_____

_____

MEDICAL AND DEVELOPMENTAL HISTORY

My child was born in _____ (City, State) at a weight of _____ pounds, ____ ounces.

Length of pregnancy: full-term (9 months) or _____ weeks/months

_____ Gravida [This child was 1st, 2nd, etc. of the total number of pregnancies]

_____ Para [This child was the 1st, 2nd, etc. live birth of all pregnancies]

_____ Abortus [Number of abortions prior to this child's birth]

Mother's age when this child was born: _____ years old

Father's age when this child was born: _____ years old

PREGNANCY COMPLICATIONS

	Not True	True	Don't Know
Alcohol use, specify:			
Cigarette smoking: (# packs per day:)			
Narcotic or illicit drug use, specify:			
Pre-eclampsia			
Eclampsia (toxemia)			
Placenta previa			
Accidents during pregnancy			
Excessive stress/emotional pressures during pregnancy			
Medication(s) prescribed (list med. and for what problem)			
Bleeding/infection/trauma in the ____ month of pregnancy			
Multiple births (twins, triplets, etc.)			
Other:			

LABOR AND DELIVERY

	Not True	True	Don't Know
Long labor, # hours:			
Labor was induced			
Forceps/suction used			
Delivery performed under general anesthesia			
Cesarean section (due to breech positioning, fetal distress, failure to progress, repeat C, etc.)			
Injury to infant during delivery, specify:			
Infant was blue at birth			
Other:			

APGAR scores were _____ (0 – 10) at one minute and _____ (0 – 10) at 5 minutes.

Length of infant's stay in hospital: _____ days / weeks

At the time of birth, my child was: healthy / in need of special medical care.

NEONATAL PERIOD (BIRTH TO TWO WEEKS)

	Not True	True	Don't Know
Infant had trouble breathing			
Infant was intubated			
Infant was on oxygen			
Infant had hyperbilirubinemia			
Infant was jaundiced, specify treatment:			
Infant had seizures, fits, convulsions			
Infant had hyaline membrane disease			
Infant had trouble sucking			
Infant had projectile vomiting			
Infant was born with congenital problems: (e.g., cardiac problems , clubbed feet, dislocated hips, growth problems, dysmorphic features)			
Infant required surgery, specify:			
Infant was "floppy" or hypotonic			
Infant was treated in a neonatal intensive care unit, # days: _____			
Other:			

Infant was fed breastmilk, formula, or a combination of breastmilk and formula for ____ months/yrs.

Colic? Yes / No If yes, specify for how long (_____ months) and if mild, moderate, or severe.

As an infant, my child's temperament was: _____

Were medications prescribed within the first year? Yes / No If yes, describe: _____

	Relevant Dates / Ages	Brief Description
Hospitalizations		
Surgeries *(include ear tubes)*		
Visits to the Emergency Room		
(Broken bones, head injuries, concussions, loss of consciousness, cuts requiring stitches, etc.)		
CT Scans, MRIs, EEGs, EKGs		
Other:		

SUBSEQUENT MEDICAL HISTORY

	Not TRUE	TRUE	Relevant Details (age, severity, evaluations, etc.)
Trouble with vision			
Trouble with hearing			
Frequent ear infections			
Allergies			
Asthma			
Pneumonia			
Seizures, fits, convulsions, absence spells			
Slow weight gain			
Excessive weight gain			
Failure to thrive			
Meningitis / Encephalitis			
Anemia (low blood count)			
Lead exposure / poisoning			
Cardiac problems			
Kidney problems (e.g., hydronephrosis)			
Headaches/Migraines			
Streptococcal Infections			
Birthmarks / Café au lait spots on skin			
Other:			

Date of last hearing screening/evaluation: _____ Results: _____

Date of last vision screening/evaluation: _____ Results: _____

Circle those that apply: My child wears eyeglasses / hearing aids.

My child's immunizations are up to date: Yes / No If no, describe: _____

Name and contact information of primary care physician: _____

_____

My child has difficulty falling and/or staying asleep: Yes / No If yes, describe: _____

_____

_____

Are you concerned about your child's eating habits? Yes / No

If yes, please describe: _____

_____

_____

PREVIOUS MEDICAL / PSYCHOLOGICAL DIAGNOSES

If your child has been evaluated by a neurologist, endocrinologist, or medical / mental health professional (neuropsychologist, psychologist, psychiatrist, etc.), please list the diagnosis or diagnoses that have been made.

Previous Evaluation / Diagnosis	Diagnosis made by (name, title)	Age of child when diagnosed

ATTAINMENT OF EARLY DEVELOPMENTAL MILESTONES

When did your child:

		Age in months or years	If you cannot recall specific time or age, please indicate if "on time" or "delayed" for age.
Language	Babble (ma-ma, da-da)		
	Speak his/her first word		
	Put two words together		
	Use "you", "mine", and first name		
	Speak clearly so strangers understood		
Gross Motor	Sit up without assistance		
	Walk independently		
	Climb up/down stairs alone		
	Ride a tricycle		
	Jump forward		
	Ride a bicycle without training wheels		
Fine Motor	Scribble		
	Draw lines		
	Draw circles		
	Draw squares		
	Tie shoelaces		
Adaptive	Use spoon		
	Start to dress self		
	Fully bladder trained at night		
	Fully bladder trained during the day		

Currently, does your child wear diapers or pull-ups during the day or at night? Yes / No

MEDICATION HISTORY

Please list medications prescribed to your child in the past or currently. Do not include antibiotics or other medications prescribed for temporary illnesses.

Name of Medication	Problem area	Dose/Freq.	Began (mo/yr)	Stopped (mo/yr)	Helpful?	Neg. Side Effects?

Physician(s) who prescribes these medications: _____

_____

PSYCHOTHERAPY HISTORY

Has your child received individual or group psychotherapy or counseling? Yes / No

If yes, please describe who provided those services and for what reasons: _____

_____

_____

Please list any special parent training workshops or programs that you have attended. _____

_____

SCHOOL HISTORY

Attended Mother's Day Out / Daycare? Yes / No From age _____ to _____

Name(s) and Location(s) of MDO/Daycare Program: _____

_____

Attended Preschool? Yes / No From age _____ to _____

Name(s) and Location(s) of Preschool Program(s): _____

_____

Please list below all other schools your child has attended, beginning with kindergarten and ending with his/her current school.

If your child was retained in school, please indicate which grade was repeated: _____

Grade	Name of School	Location	Private or Public School

TREATMENT AND SERVICES

Please indicate which of the following services that your child has received or currently receives.

Type of Service	Age or grade	Received for what problem?	Location where services were provided	Duration/Freq.
Early childhood intervention (ECI) and/or PPCD services - birth to 5 years of age				
Speech Therapy				
Oral Language Therapy				
Occupational Therapy				
Physical Therapy				
Adaptive Physical Ed.				
Summer School				
Tutoring				
Resource Room Services (specify if for rdg, spelling, writing, math, etc.)				
Content Mastery				

ADDITIONAL HISTORY

What does the child's teacher(s) think the problem is? _____

_____

_____

Please describe any other concerns about your child's difficulties in school: _____

_____

_____

_____

Describe your child's interests, hobbies, activities (e.g., sports, crafts, clubs, etc.). : _____

_____

_____

_____

How does your child spend his/her time in the afternoons and on weekends? _____

_____

_____

_____

Does your child play with other children? How does he or she get along with them? Describe the way in which you child plays whether alone or with other children. Does your child have problems making or keeping friends?

_____

_____

_____

_____

_____

Who takes care of your child during the week and on the weekends? _____

_____

_____

Describe a typical weekday for your child, beginning with when he or she wakes up. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How does your child get along with family members at home? _____

_____

_____

_____

_____

_____

How does your child get along with other adults (e.g., teachers, parents of other children)? _____

_____

_____

Describe the "bad" times for this child with each family member: _____

_____

_____

_____

_____

_____

How does your child behave when angry or when things do not go his or her way? _____

_____

_____

_____

_____

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_____

_____

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_____

Are you concerned about your child's response to discipline? Yes/No

How do you respond when your child misbehaves? What discipline strategies have you tried? Are they effective?

_____

_____

_____

_____

_____

_____

When being punished, does your child respond differently to mother versus father? Yes / No

If yes, please describe: _____

_____

_____

_____

_____

_____

_____

Does your child have a history of physical or sexual abuse or neglect? Yes / No

If yes, please describe: _____

_____

Has Child Protective Services been involved with your child or your family? Yes / No

Is there anything else about your child or situation that you would like Dr. McLane to know? _____

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END OF QUESTIONNAIRE
THANK YOU