Neuropsychology Consultants

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Parent Questionnaire

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 you will have an opportunity to further elaborate on your responses.

Date:_____

Age: ____ Birth Date:_____ Gender: _____ Grade:_____ School:_____

Child's name:_____Nickname:_____

Name of parent(s) or legal guardian(s):_____

Is there a biological or adoptive parent not present at today's clinical interview? _____

If so, is he or she aware of this evaluation? _____

Person completing form:_____

How were you referred?_____

Problems and Concerns

Please list, in order of concern, the problem(s) for which you are seeking help for your child:

A._____

B._____

C._____

D._____

E._____

F._____

G._____

Who is currently living in the child's home?

Name	Age	Education	Occupation	Relation to child

Close family members not living in the child's home:

Name	Age	Relation to Child	Frequency of contact

Please list the important changes or significant events that have occurred in your child's lifetime (for example: deaths, parent separations, divorces, remarriages, family moves, loss of important friendships, serious illnesses, financial problems, periods of parental conflict, family violence, etc.). Please provide your child's age at the time each event occurred.

Age	Change or Event

Prenatal Development

Was the pregnancy: _____with prenatal care _____without prenatal care

Age of parents at time of child's birth: _____mother _____father

While mother was pregnant, did she have any of the following:

_____medical problems_____

_____accidents/injuries_____

_____surgeries_____

_____medications_____

_____alcohol intake_____

_____tobacco use_____

_____drug use_____

_____exposure to toxic chemicals or substances_____

_____stressful events for one or both parents_____

Were there any other serious illnesses or complications?

For mother: _____

For child:_____

Delivery

How long did labor last:_____ Baby's weight at birth:_____

Was baby born at term?_____If not, at how many weeks gestation?_____

Father's level of involvement during prenatal development and delivery:_____

Length of hospital stay for mother:_____Length of stay for child: _____

Were any of the following present during or soon after delivery? (check all that apply)

_____baby was jaundiced (yellow)
_____baby was blue
_____baby needed oxygen
_____breech birth
_____baby needed blood
_____Rh factor present
_____born with cord around neck
_____baby was placed in an incubator. For how long?_____
_____other medical problems at birth_____

_____C Section performed
_____emergency C section
_____baby aspirated meconium (breathed waste)
_____baby had trouble keeping milk/formula down
_____baby had trouble sucking

_____

Developmental History

Did any of the following occur during infancy?
(check all that apply)

_____baby had problems sleeping_____
_____baby was frequently fussy or colicky_____
_____baby had unusual crying _____
_____ baby had trouble breathing_____
_____baby had problems eating or gaining weight_____
_____baby experienced convulsions, seizures, or "spells"_____
_____
_____ baby had excessive diarrhea or dehydration_____
_____ parent emotionally distressed (depression, anxiety, etc.) _____
_____
_____parent physically ill or injured _____
_____significant family stressors _____

Who was primarily responsible for the baby's care? _____

Who assisted in the baby's care? _____

Do you believe your child formed an emotional attachment to you?

___ yes ___ no

How do you feel your child developed in the following areas?

Motor development	_____ faster than average	_____ average	_____ slower than average
Talking & language development	_____ faster than average	_____ average	_____ slower than average
Relationships & social development	_____ faster than average	_____ average	_____ slower than average

Estimate the age at which the following occurs (OK to leave blank if you cannot remember):

Age		Age	
_____	spoke first word	_____	sat without support
_____	spoke in full sentences	_____	walked alone
_____	took first steps	_____	toilet trained

comments: _____

Temperament

What are the qualities you liked best about your child as a preschooler? _____

_____

_____

What were/are some troublesome qualities you noticed about your child as a preschooler? _____

_____

_____

What are the qualities you like best about your child now?_____

_____

What are some troublesome qualities you notice about your child now? _____

_____

_____

Medical History

Does your child currently have any medical conditions?_____

_____

Has your child had any serious medical conditions, injuries, or surgeries in the past?

Type Age

_____

_____

_____

Has your child ever had: a head injury? ____ yes ____ no

a seizure? ____ yes ____ no

other neurological problems ?____ yes ____ no

describe:_____

Has your child ever had:

Reason Findings

____CT scan of the brain? _____

____MRI/MRA of the brain?_____

____EEG? _____

____Sleep Study? _____

_____Psychological or neuropsychological evaluation?_____

Please write the ages (in years) that your child had any of the following illnesses:

Ages	Ages	Ages
_____ allergies	_____ frequent colds/ sore throats	_____ pneumonia
_____ asthma	_____ frequent stomachaches	_____ tonsillitis
_____ diabetes	_____ heart trouble	_____ frequent earache
_____ fainting	_____ menstrual problems	_____ tubes in ears
_____ fractures	_____ motor or verbal tics	

_____other: _____

My child's physicians are: _____

_____

_____

My child's current medications are:

Medication	Dosage	Frequency

Previous medications and how child responded:_____

_____

Does your child have any:

age of last exam

vision problems _____

hearing problems _____

sensory sensitivities (tactile, auditory, etc.) _____

_____

Please describe your child's eating habits. Note any problems in this area. _____

_____

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

_____

Has your child ever received the following professional services?

Ages	Services	Name of Provider
_____	Educational Testing	_____
_____	Psychiatric (medication)	_____
_____	Neurological	_____
_____	Counseling	_____
_____	Speech Therapy	_____
_____	Occupational Therapy	_____
_____	Physicial Therapy	_____

Has your child ever:

been subjected to abuse (physical, sexual, emotional)? ____ yes ____no

witnessed traumatic events? ____ yes ____no

expressed thoughts of self harm? ____ yes ____no

attempted to harm self? ____ yes ____no

attempted to harm others? ____ yes ____no

seen or heard things other people do not see or hear? ____ yes ____no

used tobacco, alcohol, or recreational drugs? ____yes ____no

Please list anyone in the child's immediate or extended family who has had difficulties with:

Problem	Relationship to child
depression	_____
anxiety	_____
panic attacks	_____
anger management problems	_____
bipolar disorder	_____
schizophrenia, schizoaffective, or other psychotic disorders	_____

seizures _____

autism spectrum disorder (including Asperger's syndrome) _____

intellectual disability (formerly called mental retardation) _____

dyslexia (reading disability) _____

dyscalculia (math disability) _____

dysgraphia (disorder of written language) _____

language delay _____

problems paying attention _____

hyperactivity _____

drinking problem/alcoholism _____

drug problem _____

criminal record _____

School History

Current teachers: _____

Did your child attend day care? _____ How old was your child when s/he started? _____

If yes, describe the setting and the child's reaction to it. _____

_____

Please list below the previous day care centers, preschools, and schools attended:

School	Location (City, State)	Grade

As best you can recall, please provide a general description of your child's academic progress and/or concerns in each grade.

Pre-K_____

Kindergarten_____

First_____

Second_____

Third_____

Fourth_____

Fifth_____

Sixth_____

Seventh_____

Eighth_____

Ninth_____

Tenth_____

Eleventh_____

Twelfth_____

Has your child ever repeated a grade? _____ yes___ no If yes, what grade and what was the reason?_____

_____

Is your child currently receiving the following academic services from the school?:

_____ Special Education _____ 504 _____ other accommodations

If so, what specific services and when did they start? _____

_____

_____

If not currently, have they received services in the past? _____

Please rate your child's current academic performance

Subject	below grade level	at grade level	above grade level
Reading or English	_____	_____	_____
Writing	_____	_____	_____
Math	_____	_____	_____
Spelling	_____	_____	_____
Other:_____	_____	_____	_____
Other:_____	_____	_____	_____
Other:_____	_____	_____	_____

Social Functioning

How does your child get along with:

Younger children _____

Peers _____

Older children _____

Teachers _____

Does your child have friends? _____

What are their typical activities when together? _____

Please list any organizations, clubs, teams, or groups that your child belongs to: _____

_____

Please list any other special interests, hobbies, or activities: _____

_____

Family Functioning:

How does your child get along with:

Parents: _____

Siblings:_____

Please list any jobs or chores that your child has. _____

_____

My child is disciplined by (check those that apply):

_____ mother _____ father _____ other

Discipline most often used (in order of frequency) _____

_____

Discipline that is most effective: _____

_____

Other Important Information

Please provide any other information about your child or your family that you think might be important in understanding the problems that have led you to seek treatment.

_____

_____

_____

_____

_____

_____

_____

_____