PARENT QUESTIONNAIRE

Dear Parent or Guardian,

I look forward to meeting you and your child and evaluating your child's cognitive/neurologic development as requested. Your answers on this questionnaire will help me understand your child's health, neurologic functioning, learning skills, and behavior. Please list your concerns and provide all information you feel may be relevant.

Similar questionnaires are enclosed for you to give to your child and to your child's teacher or school counselor to complete.

Thank you very much.

Childs Name	Birthdate
Relationship to Child	
Address	
City , State, Zip	
Home Phone	Work Phone
School Name	Grade
Teacher Name/Phone	

What are your concerns, questions, and goals regarding your child's learning, development, neurologic functioning, and/or behavior? (Feel free to attach additional pages if necessary.)___

____

What made you decide to obtain this evaluation?.

____

GENERAL HEALTH HISTORY
Please check any of the following which were (or are) true for your child:

Pregnancy Problems: Please
Explain:

- excessive maternal weight gain ☐
- failure to gain weight ☐ ________
- excessive vomiting ☐ ______
- excessive bleeding ☐ ____
- exposure to medication(s) ☐ ___
- exposure to alcohol ☐ ___
- exposure to cigarettes ☐
- exposure to other substances ☐
- prior miscarriages or premature births ☐

Birth History:
- premature birth ☐
- prolonged birth (>12 hours) ☐
- difficult delivery or C-section ☐
- twins, placenta abruption, or placenta praevia ☐
- birth injury ☐
- baby needed resuscitation ☐
- breathing problems ☐
- heart, skin, kidney, or other organ problems ☐
- jaundices ☐
- seizures
- spina bffida, other ☐
- neurologic problems unusual features Infection

If you checked any of the above please explain:

Birth Weight		Length of stay in Hospital	

Medical History:

Does your child take any medications? ☐ Yes ☐ No
If yes, list below

Name of Drug	Dose

Has your child ever:

had surgery? ☐
been hospitalized? ☐
been exposed to poison/overdose? ☐
been injured seriously? ☐

Has your child had problems with:

eyes/vision ☐
ears/hearing ☐
heart ☐
lungs ☐
abdomen ☐
kidneys/genitals/bladder ☐
immune infection ☐
musdes/bones/foints ☐
neurologic function ☐
_____ seizures ☐
___ headaches ☐
______ floppiness/stirmess ☐
___ balance problem ☐
___ coordination problem/clumsiness ☐
____ weakness ☐
___ endurance problem ☐
___ loss of consciousness/head trauma ☐
___ meningitis/encephalitis ☐
____ involuntary movements ☐
____ muscular dystrophy ☐
___ spina bifida/mentngomyelocele ☐
___ other neurologic problem ☐

Please give further details about any problem you checked above. (Attach additional page if necessary.)

Does your child have any allergies to medications? ☐ Yes ☐ No ________________________________

Has your child had chickenpox? ☐ measles? ☐ mumps? ☐ rubel!* ☐ roseola?

Are your child's immunizations up to date? ☐ Yes ☐ No

DEVELOPMENT HISTORY

At approximately what age did your child begin to:

sit alone ___	
Crawl	
walk alone	
walk up stairs	
ride a tricycle	
play ball/throw and catch	
use two or more words together	
speak dearly	

feed self	
with which hand?	
dress self	
hold a pencil wefl	
write	

Overall, how old a child does your child seem like now?

Were you ever concerned about your child's language, social, or motor development?
☐ Yes ☐ No

PERSONALITY/BEHAVIORAL HISTORY:

The following is a list of a wide variety of issues which may be of concern. Please check the appropriate column for this child for each issue.

	Average For Age/Not A Problem	More Than Average/ Somewhat Problematic	Significant Problem Or Concern
Sadness/Depression			
Anxiety/Worry			
Low Setf-EsteenVConfidence			
Variable Moods			
Easily Frustrated			
Easily Angered/Irritable			
Crying/Tantrums			
Aggression/Fighting			
Defiance/Disobedience			
Destructive Behavior			
Truancy/Running Away			
Lying Or Stealing			
Rejection By Peers/Unpopular			
Gets Teased			
Teases Others/Cruelty			
Isolation/Loneliness			
Passive Behavior/Eager To Please			
Shyness/Mistrust			
Clowning/Acting Out/Disruptive			
Pesters Others			
Manipulative/Controlling			
Frequent Pains/Physical Complaints			
Accident Prone			
Acts Without Thinking			
Hurries Through Tasks			
Short Attention Span			
Misses Key Information			
Easily Distracted			
Daydreams			
Says Irrelevant Things			
Daytime Sleepiness/Easily Fatigued			
Easily Bored/Restless			
Difficult To Satisfy			
Fidgety/Overly Active			
High Energy Level			
Variable Performance (Unpredictable Quality Of Work/Inconsistent Grades)			
Eating Or Appetite Problems			
Sleep HaMs/tnsomnia/Sleepwalks			
Wets Or Soils			
Head-Bangs/Other Self-Injurious Behavior			
Rocks/Other Repetitive Habits			
Hordes Things			
Repetitive Acts/Compulsions			
Sees Or Hears Things That Are Not There			
Uses Drugs Or Alcohol			
Sudden Twtehes/Blinks/Ncds			
Unusual Grunts Or Other Sounds			
Difficulty Giving Or Receiving Affection			
Inflexible/Difficulty With Changes			

Do you **have** any other concerns about personality, emotional, or behavioral functioning? ☐ Yes ☐ No

Feel free to explain any of your responses more fully.

SCHQOLHISTORY

Please describe your child's current school placement (grade and type of class)..

Does your child receive any special help now in or out of school, and rf so, what kind and how often?

Did your child previously receive any special help? ☐ Yes ☐ No

Has your child had any previous evaluations? Do you know or have t he results? If you have copies of these evaluations, please bring them along with you to your appointment. Also, please bring report cards and samples of schootwork if possible.

speech/language evaluation ☐ **Yes** ☐ **No**
achievement tests ☐ **Yes** ☐ **No**
psychological evaluation or 1Q tests ☐ **Yes** ☐ **No**
psychiatric evaluation ☐ **Yes** ☐ **No**
neurologic evaluation ☐ **Yes** ☐ **No**
__ physical/occupational evaluation ☐ **Yes** ☐ **No**
Did your child attend preschool? Kindergarten? ☐ **Yes** ☐ **No** ______________________________
Was your chad ever retained a grade ? ☐ **Yes** ☐ **No**___________________________________

Please rate your child's skills in the following areas:

ACADEMIC PERFORMANCE:

	Weakness Compared To Others	Average	Strength Compared To Others
Speech/Language:			
Pronunciation			
Stuttering			
Understanding Others			
Hearmg/Usterung			
Other			
RMdtng:			
Aloud			
Silently			
Reading Rate			
Recognition Of Words			
Phonics			
Comprehending What Was Read			
Remembering What Was Read			
Spelling:			
Accuracy			
Consistency			
Writing:			
Legibility/ Coordination			
Remembering Letter Shapes			
Punctuation			
Sentence Structure/Organization			
Sophistication OF Ideas			
Mathematics:			
Understanding The Question			
Remembering How To Do The Problem/Basic Skids			

	Weakness Compared To Others	Average	Strength Compared To Others
Word Problems/ Applications			
History/Social Studies			
Science			
Foretqn Language			

About how much time a week do you spend working with this child

on homework, reading, etc.

Do you have any other concerns about academic

skills/development?

Feel free to explain any of your responses more fully.

STUDY STRATEGIES/OTHER CHARACTERISTICS:

	Weakness Compared To Others	Average	Strength Compared To Others
Note-Taking Skills:			
Rate/Keeping Up			
Identifying Key Concepts			
Concentration/Attention			
Comprehension Of Orally/Aurally Presented Material			
Comprehension Of Written/Visually Presented Material			
Study fig:			
Memorization			
Organization			
Allowing Appropriate Trne			
Concentration			
Assignment*			
Attention To Ins truction			
Comprehension Of Task			
Checking Work			

Allowing Appropriate Tfne/Uvng Appropriate Books And Supplies			
Completion Of Task			
Response To Feedback			
Consistency Of Performance			
T**t Taking:			
AnxJety/Chofcinq Up			
Pacing/Organization			
Recall Of Facts			
Consistence Of Performance			
Class Participation:			
Attention/Staying On Subject			
Enthusiasm/Curiosity			
Social Skills			
Other			
Talking In Class			
Leaving Seat/Disruptive			
Bothering Others			
Athletic Ability			
Imagination/Creativity			
Sense Of Humor			
Flexibility/Acceptance Of New Ideas			

Do you have other concerns about study strategies/other characteristics? ☐ Yes ☐ No

Peel free to explain any of your responses more fully.

FAMILY AND SOCIAL HISTORY:

What sports or hobbies does your child enjoy?

Is your child involved in any organized activities (team sports, scouts, etc}?☐ Yes ☐ No

Any pets? ☐ Yes ☐ No

Who does your child live with? (Please lisst names and ages of household members)

Child's Mother's Name	Age
Education	Occupation

Significant health problems	

Child's Father's Name	Age
Education	Occupation
Significant health problems	

Does anyone in the family have a history of:

- learning problems ☐ ____
- attention ☐
- behavior problems ☐
- tics/involuntary movements ☐
- seizures bim") defects or ☐
- hereditary conditions chronic ☐
- illness or disability ☐

What causes or sources of stress do you know of in your child's life?

Is there anything else of concern to you which you would like for me to know?

Please attach a fairly recent photograph of your child if one is available.

Thank you very much.