



Parent Questionnaire

Please fill out this questionnaire and answer all questions with as many details as you can provide. We will need to receive the completed questionnaire at least a week before your initial consultation. Failure to provide us with this information will limit our ability to constructively use your time. (If you are not comfortable with the PDF format, please contact the above mentioned phone to get a printed copy.)

Child's Information

Child's name _____

Date of birth _____ SS# _____

Grade _____

School _____

Pediatrician _____

Any current medical problems, including allergies and a list of all current and past medications. _____

Mother's Information

Mother's name _____

Occupation _____ Age _____

Address _____

SS# _____

Father's Information

Father's name _____

Occupation _____ Age _____

Address _____

SS# _____



Parent Questionnaire

1. What is the main problem you would like to get help for? _____

2. Does the child live with both parents, mother, father or other relatives, who have legal custody of the child?

3. What is parental style in the household, how are children disciplined, are there differences between parent's styles (please be specific) and how they are manifested?

4. Immediate/extended family history of emotional/mental health, chemical dependencies, and other problems.



CHILDREN'S
TREATMENT CENTER

Phone 860.561.5515
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5. Siblings, ages, schools, any health/mental health problems_____

6. Pregnancy, what age, planned/unplanned, previous pregnancies, how many, complications, outcomes of each pregnancies before. Pregnancy with the identified patient: medical problems (high blood pressure, toxicosis, spotting, edema, bed rest, etc), any medications/alcohol/ drugs in pregnancy; if so, how often, how much?

7. Delivery: spontaneous, was baby full term, forceps, C-section, etc._____

8. Birth: Apgar score, any medical concerns, breathing, feeding/breast feeding, how soon released from the hospital, jaundice, light therapy, any inpatient admissions from birth to 1st month.



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9. Early development: developmental milestones starting from birth up to 12 mos, any medical concerns, delays, allergies, medical conditions.

10. Toddler: physical, emotional and cognitive development, day care, nursery school etc, any behavioral problems there.

11. From 3 to 5 years: social experience, cognitive development, favorite pass time, favorite toys, including any preoccupations that you consider unusual.

12. How does your child respond to the presence of strangers? _____



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13. From 5 to 7 years: transition to school, social adaptive skills, academics, any problems, please describe

14. Middle school: grades, social skills, friends, favorite things to do, sport, relationship with parents and siblings.

15. High school: describe transition from middle school to HS, any changes in academic performance, habits, social life, and possible drugs or alcohol.

16. Does the child sleep well? YES / NO

17. Does he or she have nightmares? YES / NO

18. Does he or she wakes up cranky, in bad mood? YES / NO

19. Is it difficult to complete the morning routine? YES / NO



Parent Questionnaire

20. Is it hard for child to separate from you? YES / NO
(If you answered YES, please describe any difficulties you have.)

21. Any problems on a school bus? YES / NO

22. Does your child have problems taking directions from parents or teachers? YES / NO
(If you answered YES, please describe any difficulties you have.)

23. Has your child been recommended for any special academic program or requested a special meeting to discuss educational planning? YES / NO
(If you answered YES, please describe any difficulties you have.)



Parent Questionnaire

24. Has your child received psychological or neuropsychological testing?
(If you answered YES, please arrange for these reports to be forwarded to our office)

25. Has your child school voiced any concerns about levels of attention and concentration? YES / NO
(If you answered YES, please describe any difficulties you have.)

26. Did your child have any traumatic experience or witnessed such, including physical/sexual violence (exposure)?

Your child...

27. ...is unusually aggressive YES / NO

28. ...understands basic rules of social behavior YES / NO

29. ...looses temper quickly YES / NO

30. ...has difficulties complying with rules YES / NO

31. ...is able to take responsibility for his or her actions or does he/she blame them on others YES / NO

32. ...is excessively temperamental and does it express (property destruction, slamming, throwing, swearing, pouting, sulking etc.) YES / NO

33. ...looses belongings excessively YES / NO

34. ...has problems waiting in lines YES / NO

35. ...talks out of turn YES / NO

36. ...has any history of difficulties with law, including fire-setting, stealing, shop-lifting etc. YES / NO

Parent Questionnaire

Your child...

37. ...cannot take "no" for an answer YES / NO
38. ...is hyperactive and easily excitable YES / NO
39. ...has difficulties settling at night YES / NO
40. ...has drastically different level of energy and activity between mornings and nights YES / NO
41. ...has many ideas at once and talks about them in a rapid and disorganized way YES / NO
42. ...displays abrupt rapid mood swings YES / NO (if answered YES, please describe specifically)
43. ...has difficulties falling asleep YES / NO
44. ...is easily distracted YES / NO
45. ...has difficulties with transitions YES / NO
46. ...avoids homework YES / NO
47. ...has poor organizational skills YES / NO
48. ...is excessively sensitive to tastes, smells, textures etc. YES / NO
49. ...does not have any sense of danger or fear, displays risky behavior YES / NO
50. ...is fidgety, has difficulties sitting still YES / NO
51. ...at times gets goofy or silly YES / NO
52. ...significantly overvalues his skills or talents YES / NO
53. ...becomes argumentative, does not know when to stop YES / NO
54. ...is preoccupied with violent games or fantasies YES / NO
55. ...makes threats of violence to self or others YES / NO
56. ...is engaged in self-destructive behaviors including cutting, scratching, burning (please describe any concerns about other self-destructive behavior)

Parent Questionnaire

Your child...

- 57. ...shows age inappropriate sexual behavior YES / NO
- 58. ...often feels bored and does not know how to occupy his or her time YES / NO
- 59. ...is sensitive to criticism YES / NO
- 60. ...significantly undervalues his/her skills or talents YES / NO
- 61. ...feels excessively shy in social situations YES / NO
- 62. ...has decreased drive/energy YES / NO
- 63. ...feels easily ashamed, blames him/herself YES / NO
- 64. ...has an imaginary friend(describe) YES / NO
- 65. ...talks to an invisible person YES / NO
- 66. ...is excessively afraid of being kidnapped, or physically hurt by unknown enemies YES / NO
- 67. ...believes that he/she is controlled by supernatural forces YES / NO
- 68. ...is a picky eater YES / NO
- 69. ...has experienced a weight loss/gain of 20lb or more in a 2 month period YES / NO
- 70. ...eats inedible or unusual substances YES / NO
- 71. ...eats large amount of food in one sitting YES / NO
- 72. ...vomits after meals YES / NO
- 73. ...uses water pills or laxatives for weight control YES / NO
- 74. ...spends excessive amount of time in the bathroom YES / NO
- 75. ...has problems with bowel movement YES / NO
- 76. ...has distorted body image YES / NO
- 77. ...has unusual rituals YES / NO



Parent Questionnaire

Your child...

78. ...shows perfectionism, which interferes with task completion YES / NO
79. ...shows rigidity and stubbornness YES / NO
80. ...is reluctant to work with others unless they submit to his or her way of doing things YES / NO
81. ...is preoccupied with details, rules, order and organization YES / NO
82. ...fails to develop peer relationship YES / NO
83. ...lacks social/emotional reciprocity YES / NO
84. ...has delayed or total lack of development of spoken language YES / NO
85. ...has stereotyped and repetitive use of unusual language structure YES / NO
86. ...lacks eye contact YES / NO
87. ...has inflexible adherence to nonfunctional routines or rituals YES / NO
88. ...has repetitive motor mannerism (hands or fingers flapping or twisting or repetitive whole body movements) YES / NO
88. ...has tics, motor or vocal YES / NO
89. Is there any other information you think we need to be aware of?

Mother's Signature _____ Date _____

Father's Signature _____ Date _____