

PARENT QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____

Nickname: _____ Age: _____ Grade: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Cell: _____

Email: _____

Primary Physician: _____ Phone: _____

Medical Diagnosis (if known): _____

Current Medications:

1. _____ 2. _____ 3. _____

Current Precautions: _____

Family:

Father's Name: _____ Age: _____ Employer: _____

Mother's Name: _____ Age: _____ Employer: _____

Child lives with: _____ Languages spoken at home: _____

Name & ages of other children living at home:

NAME

AGE

Child's Doctors- please list any Physicians your child has seen in the last three years:

Name

Phone

Physical/Developmental History:

Prenatal- Any medical problems before pregnancy: ___yes ___no

Describe if yes: _____

Problems (Mother) during this pregnancy: ___yes ___no

Describe if yes: _____

Problems (baby) during this pregnancy: ___yes ___no

Describe if yes: _____

Was pregnancy:

Full Term ___ Premature ___ Late ___ Multiple _____

How many weeks: _____

Birth:

Type of delivery:

Head first ___ Feet first ___ Forceps ___ Vacuum assist ___

Spontaneous ___ Planned C-Section ___ Unplanned C-Section ___

Duration of labor: _____ Medications given (if known) _____ Birth weight: _____

Any problems at birth? ___Yes ___No Anoxia (blue) ___ Jaundice (yellow) ___ Cleft ___

Respiratory issues ___ Sleepy ___ other _____

Medications required for baby at birth: _____

Procedures required for baby at birth: _____

Additional hospitalization required for baby: ___Yes ___No

Reason: _____

How long: _____

Infancy/Early Childhood:

Does or did your child do these things at an age appropriate level?

- | | | |
|--------------------|--------------------|--|
| Held up head | Y__ N__ when _____ | Age at first word _____ when _____ |
| Sat unsupported | Y__ N__ when _____ | Age at naming things _____ when _____ |
| Crawled | Y__ N__ when _____ | Age at using 2-3 word sentences _____ when _____ |
| Walk alone | Y__ N__ when _____ | Used words Y__ N__ when _____ |
| Name things | Y__ N__ when _____ | Used short sentences Y__ N__ when _____ |
| Drank from a cup | Y__ N__ when _____ | Fed self with spoon Y__ N__ when _____ |
| Fed self with fork | Y__ N__ when _____ | Toilet trained Y__ N__ when _____ |

DOES OR DID YOUR CHILD:

Play with sounds	Y__ N__ when_____	Babble	Y__ N__ when_____
Use Jargon	Y__ N__ when_____	Use words	Y__ N__ when_____
Talk in sentences	Y__ N__ when_____		
Use clear sounds	Y__ N__	Used words correctly	Y__ N__

Medical/Dental/Feeding History:

Y	N		Y	N	
___	___	ear infections	___	___	ADHD/ADD
___	___	tubes--Date(s):_____	___	___	takes medication _____
___	___	frequent colds	___	___	Autism/Asperger
___	___	allergies---to what: _____	___	___	reflux
___	___	surgeries---Date(s):_____	___	___	problems with feeding
___	___	asthma	___	___	drinking from cup __straw__Sippy__
___	___	vision tested--Date(s):_____	___	___	easily gags
___	___	hearing tested--Date(s):_____	___	___	diet restrictions--types: _____
___	___	difficulty socializing with peers'	___	___	eats variety of food
___	___	difficulty socializing with adults'	___	___	pacifier
___	___	tonsils removed--Date: _____	___	___	sucks thumb
___	___	adenoids removed--Date: _____	___	___	tolerates tooth brushing
___	___	mouth breather	___	___	tongue thrust
___	___	sleep apnea	___	___	sensory aversions
___	___	Syndrome: _____	___	___	seizures
___	___	falls a lot	___	___	MRI or CT scans--Date: _____

Significant Family Medical History:

Father: _____ Mother: _____
Siblings: _____ Other: _____

School History:

Early childhood intervention program (ECI): ___Y ___N Program name: _____

Progress made: ___Y ___N

Preschool/PPCD: ___Y ___N School Name: _____

Progress made: ___Y ___N

Elementary School(s) attended:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Has patient had prior Therapy? ___Y ___N progress made: ___Y ___N

Where: _____

Social:

Gets along most of the time with family members: ___Y ___N Peers: ___Y ___N

Adapts to change in routine:

___ with great difficulty ___ with some difficulty ___ no difficulty

Plays regularly with at least one friend in age group: ___Y ___N

Tends to be a: ___ leader ___ follower ___ plays by himself/herself

Plays appropriately from his/her age: ___Y ___N

Uses pretend play: ___Y ___N

Follows the rules most of the time:

At home: ___Y ___N At School: ___Y ___N Has trouble often: ___Y ___N

Social behavior compared to same age peers is: ___ below average ___ average ___ above average

How do you discipline your child: _____

Why are you seeking Therapy for your child:
