PARENT/GUARDIAN QUESTIONNAIRE

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All questions contained in this questionnaire are strictly confidential.
Please bring this form with you to your appointment, return in the mail, or email to mcrisler@alapsych.com

Client Information

Client's First, MI, Last Name _____ DOB_____
Age:____ Gender____ Ethnicity _____ SS#_____
In school or day care? Y___ N___ Grade____
Home address (street, city, zip) County
_____ _____
Father's Name:_____ DOB_____ Education_____
Employment:_____ Business Phone_____

Mother's Name:_____ DOB_____ Education_____
Employment:_____ Business Phone_____

Email: _____
Best phone number to contact you _____ Alternate_____

FAMILY DATA

Parents are: Married ___ (Date: _____) Divorced ___ (Date: _____) Widowed ___ (Date: _____)
Separated ___ (Date: _____) Single/Never married ____ (Date:_____)

Client's legal guardian: Both birth parents ___ Birth Mother ___ Birth Father___ Adoptive Parents ___
Department of Human Resources ___ Legal Guardian ___

Client lives with: Both parents ___ Mother ___ Father ___ Other___

Please list all individuals, and their relationship to the client, including parents who are currently living in the home: _____
_____

Is this a foster home placement? Yes ___ No ___ Adopted Yes ___ No ___
Age at placement: ____ Age at adoption _____

Other important/influential people frequently in client's life (who do not reside in the home?
_____
Are there any current custody issues? Yes ___ No ___
If yes please explain.
_____

If applicable, what are the custody or visitation agreements? _____ _____

Has the Department of Human Resources (DHR) ever been involved with this client? Yes _____ No ___ Dates of HR involvement_____

Reasons for DHR involvement: _____

List names and ages of all siblings (step/half siblings also):

Name:	**Age:**	**Relationship (step/half)**	**Current Grade**	**Learning/Medical Problems**

Who will be attending the evaluation? _____ _____

Do all parties involved in the care of the child agree on the need for an evaluation of this child? _____ _____

Who referred you to Alabama Psychological Services Center? _____

Phone number: _____ Why were you referred? _____

In what ways do you think this visit could be most helpful to you?

_____ _____

Pregnancy History- Mother

While you were pregnant, were you under a doctor's care? Yes___ No ___

Mother's age at time of birth _____ Length of pregnancy _____ Miscarriages _____

During this pregnancy did you have:

Condition:	**Y/N**	**Describe**
Anemia	_____	_____
Elevated Blood Pressure	_____	_____
Toxemia/Eclampsia	_____	_____
Swollen Ankles	_____	_____
Gestational Diabetes	_____	_____
Placenta Previa	_____	_____
Bleeding	_____	_____
Measles	_____	_____
German Measles	_____	_____
Flu	_____	_____
Other Virus	_____	_____
Vomiting	_____	_____
Injury	_____	_____

Medication During Pregnancy	_____	_____
Emotional Problems	_____	_____
Threatened Miscarriage or Early contractions	_____	_____
Alcohol, drugs, tobacco use	_____	_____
Other?	_____	_____

Birth History:

How long was labor? _____

Were you given medication? Yes ____ No ____ What kind? _____

Did you have natural childbirth? Yes ___ No ___

Were you under anesthesia during childbirth? Yes ___ No ___ Don't know ___

Was labor induced? Yes ___ No ___ Was induced labor planned? Yes _____ No ___

Type of Delivery: Head first ___ Feet first ___ Caesarian ____

Was the delivery unusual in any way? Yes___ How? _____ No ____

Did you have a Cesarean? Yes ___ No ___ Complications? _____

Did you have twins? Yes ___ No ___ Which born first? _____

Did this baby have:

Breathing problems? Yes ___ No ___ Don't know __

Cord around neck? Yes ___ No ___ Don't know ___

Did this baby cry quickly? Yes ___ No ___ Don't know ___

Was this baby's color normal? Yes ___ No ___ Blue ___ Yellow ___ Don't know ___

Was oxygen used for the baby? Yes ___ No ___ Don't know ___ How long? _____

Was the baby premature? Yes ___ No ____ How much? _____

What did the baby weigh? _____ Apgar Scores? _____ Was baby in incubator? Yes ___ No___

Neonatal Intensive Care?

Yes ___ No ___

Did you take the baby home with you from the hospital? Yes ___ No ____ How long after? ____

Did you have problems with feeding? Yes ___ No ___ Describe: _____

Was the baby normally active? Yes ___ No ___ Describe: _____

Defects/Problems noted at birth or shortly after? _____

Feeding

Breast Fed? Yes ___ No ___ When weaned from breast? _____ Bottle fed? Yes ___ No ___

Type: _____ When weaned from bottle? _____

Nursing or feeding problems? Yes ___ No ____

Colic? ___ Vomiting? ___ Sucking problems? ___ Swallowing problems? ___ Chewing problems? ___

Were vitamins given?_____

Child's weight at 6 months: _____ Weight at 1 year _____ Current weight _____

Current feeding method: (check all that apply): Bottle fed ___ Baby food ____ Table food _____

Is client on a special diet? Does he/she take any nutritional supplements? If yes please describe:
_____

Is client a picky eater? If so, what foods will he/she eat? _____
_____

Describe his/her appetite and eating habits at present. _____
_____

Development: Indicate age at which he/she began performing these behaviors.

Smiled in response to adult or his/her voice: _____ Eye control _____ Head control _____
Roll over _____ Sat unsupported _____ Crawl _____ Walked _____ Coo/babble_____
First words _____ First short word First tooth _____ Bladder trained _____ Bowel trained _____
Dressed self _____ Handled toys with hands _____ Finger fed _____ Began solid foods _____
Stood alone _____ Phrases _____ Out of diapers _____ Fed self with spoon _____

Any period of failure to grow or unusual growth? _____

Were you ever concerned regarding any area of his/her development? ____ If yes, how old was he/she when you first became concerned? _____
What were your concerns? _____

Has his/her speech been evaluated? Yes ___ No ____
If yes, who tested? _____When tested? _____
What were the results? _____
_____
Do you consider his/her speech and language development similar to other's his/her age? Yes ___ No ___ If no please explain
_____
_____

What language does your child speak? _____ What languages are spoken in the home and how often are they used? _____

He/she communicates by which of the following? (Check all that apply)
Crying ____ Playful sounds ____ Pointing with index finger ____Sentences ____ Sign language ____
Picture communication_____ Words ____ Phrases _____

How much of his/her speech is understandable to you? Some ____ Most ____ All _____
How much of his/her speech is understandable to others? Some ____ Most _____ All _____
Does he/she have any problems understanding what someone says? Yes ____ No ____
Does he/she have any problems talking? Yes ____ No ____

Has his/her hearing been tested? Yes ____ No ___ If yes, who tested? _____
When tested? _____ What were the results? _____
Describe his/her response to sound (eg responds to all sounds, responds to loud sounds only, extremely sensitive to loud noises, etc) _____

Has his/her vision been tested? Yes ___ No ___ If yes who tested? _____
When tested? _____ What were the results? _____

Does he/she have difficulty walking, running, or participating in other activities that require small or large muscle coordination? Yes ____ No ___
If yes please describe _____ Hand preference Left ____ Right ____ Not sure ____

Does he/she have outbursts or meltdowns due to anger, frustration, and/or sensory overload? If so, are there strategies that you have used that are helpful in correcting the behavior?

_____

FAMILY HISTORY:

Has SOMEONE IN THE CLIENT'S FAMILY (immediate household or extended family) had problems with any of the following?

	Specify if appropriate	**Person's relation to child**	**Which side of the family?**
Learning problems			
Mental Retardation			
Developmental Delay or Disability			
Speech/Language Problems			
Genetic Condition (e.g., Down's Syndrome, Fragile X)			
Other conditions (e.g., Cerebral Palsy, Fetal Alcohol Syndrome)			
ADHD or ADD			
Autism Spectrum Disorder/PDD			
Trouble with law			
Alcohol/drug abuse			
Behavior Problems as a child			
Visual impairments			
Hearing impairments			
Seizure Disorder			
Thyroid Problems			
Diabetes			
Chronic Illness			
Tics or Involuntary Movements			
Depression			
Excessive Anxiety/Worry/Fears			
Obsessive-Compulsive Disorder			
Mania/Bipolar			
Psychosis/Schizophrenia (E.g., sees hears things not there, has unusual thoughts)			

Has he/she been given any of the following diagnoses? If yes when was the diagnosis given? By whom?

Autism	Yes _____ No _____	When? _____ By whom? _____
Asperger's Disorder	Yes _____ No _____	When? _____ By whom? _____

Pervasive Developmental Disorder, Not otherwise specified	Yes _____ No _____	When? _____ By whom? _____
Fine Motor Delays	Yes _____ No _____	When? _____ By whom? _____
Sensory Concerns or Sensory Integration Disorder	Yes _____ No _____	When? _____ By whom? _____
Articulation Delays	Yes _____ No _____	When? _____ By whom? _____
Receptive or Expressive Language Disorder	Yes _____ No _____	When? _____ By whom? _____
Social Pragmatic Communication Delays or Social Delays	Yes _____ No _____	When? _____ By whom? _____
Mental Retardation or Learning Disabilities	Yes _____ No _____	When? _____ By whom? _____
Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder	Yes _____ No _____	When? _____ By whom? _____
Anxiety/Excessive fears/worries	Yes _____ No _____	When? _____ By whom? _____
Tics or involuntary movements	Yes _____ No _____	When? _____ By whom? _____
Depression	Yes _____ No _____	When? _____ By whom? _____
Obsessive-Compulsive Disorder	Yes _____ No _____	When? _____ By whom? _____
Oppositional Defiant Disorder/Disruptive Behavior Disorder	Yes _____ No _____	When? _____ By whom? _____
Conduct Disorder	Yes _____ No _____	When? _____ By whom? _____
Mania/Bipolar	Yes _____ No _____	When? _____ By whom? _____

Psychosis/ Schizophrenia	Yes _____ No _____	When? _____ By whom? _____

Client History

Has client experienced	Yes	No	Specify or Describe
Abuse (physical, verbal, or sexual)			
Neglect			
Parent Divorce			
Witnessed Domestic Violence			
Experienced death of close relative or friend			
Has parent, sibling, or other close relative with severe medical problems			
Suspended or expelled from school			
Learning difficulties			
Excessive shyness			
Excessive worries/fears			
Overactivity			
Trouble paying attention			
Trouble with law			
Frequent temper tantrums			
Violence towards others, including physical fights			
Depression			
Suicidal thoughts or attempts			
Had traumatic experience			
Alcohol/Drug use			
Trouble making friends			
Frequently bullied by others			
Bullies others			

Medical History of Client

Has client had:	Yes	No	Describe (provide age)
Measles			
German Measles			
Mumps			
Chicken Pox			
Whooping Cough			
Diphtheria			
Flu			
Meningitis			
Encephalitis			
High Fever			
Frequent Ear Infections			

Allergy (food/environment/medication)			
Convulsions/ Seizures (spells)			
Injuries to head			
Colds			
Dizziness			
Pneumonia			
Tonsillitis			
Sleep Problems			
Draining Ear			
Croup			
Headaches			
Growth Problems			
Sinusitis			
Lead Poisoning			
Asthma			
Other injuries			
Other illnesses			
Hospitalizations			
Operations			
Vision Problems/ Needs glasses			
Hearing Loss			

Does he/she have a specific medical diagnosis? Or a significant health problem?
_____

How would you describe him/her?

_____ Usually very active _____ Active sometimes, but can play quietly _____ Usually not active

_____ Usually happy _____ Can be moody _____ Demands attention

_____ Aggressive towards self or others _____ Difficulty attending to activities

_____ Prefers motor activities _____ Prefers sit-down activities

As compared with others the same age, do you think his/her development is:
Below Average _____ Average _____ Above Average _____

Describe client's sleeping pattern now. Are there nightmares or night terrors now or in the past? _____
_____

What does the client enjoy doing in his/her free time? _____
_____

What are his/her special interests, likes, and dislikes? What rewards or motivates him/her? _____
_____

What have you found to be the most effective form of discipline? _____
_____

Is the discipline at home handled mostly by: Mother _____ Father _____ Both _____

Describe his/her reaction to discipline. _____
_____

What about when given instructions or told to do something? _____
_____

What does he/she do if told no? _____

How does he/she get along with other children in the family? _____
_____

How does he/she get along with children/loved ones not in the family? A leader? Follower? Playing with children who are older? Younger? _____
_____

What is the age and sex of your child's favorite playmate/friend? _____

Describe any moody periods. _____
_____

Describe any problems with awkwardness or clumsiness. _____
_____

Describe any problems with sitting still or paying attention. _____

_____

_____

Describe how he/she behaves in public (stores, restaurants, movies, etc.) _____
_____

Please name three social goals that you would like for him/her to accomplish this year:
_____
_____

Educational Information

School attending: _____ Teacher: _____

Client's present grade: _____ Has client repeated a grade? Which one and why? _____
_____

Currently placement in school: Regular classroom? _____ Special Education classroom _____
Resource room _____ Alternative school _____ other (explain) _____
Home school _____ If homeschool, who/which organization is it through (church, etc.)_____

What homeschool curriculum is used? _____

Has he/she been suspended this school year? Yes _____ No _____ If yes why? _____
_____

Have there been many changes in his/her school setting? _____ If yes, please explain: _____
_____

Has client attended Nursery School? _____ Prekindergarten? _____ Kindergarten?_____

Has the client been evaluated by the school? If so, what were the results? _____
_____
_____
_____

If your child has received any of the following special services, please give age when services started and the date services ended, or current frequency of services.

Therapy Type	**Grade/Age of Child when services began**	**If appropriate, date services ended**	**Current frequency of services**	**Specific goals being addressed**
Physical Therapy				
Occupational Therapy				
Speech/language therapy				
Special instruction				
Vision impaired				
Hearing impaired				
Psychologist/Counselor				
Social Skills				

On average, what are his/her grades this year _____

In what classes does he/she do well? _____

In what classes does he/she struggle? _____

Has there been any big changes in his/her grades (for example, s/he was passing, now failing?) _____
_____
If yes, describe (when did it start? What classes?) _____

History of Grades:

On average, what were his/her overall grades for the following school years: (For example, mostly Bs, ranged from Cs to Fs; straight As)

Year in school	Average grades	Year in school	Average grades
Kindergarten		7th	
1st		8th	
2nd		9th	
3rd		10th	
4th		11th	
5th		12th	
6th			

Does he/she enjoy and feel successful in school? _____ Please explain _____
_____

Has the teacher told you that he/she is having difficulty? _____

If yes, is the problem related to learning or behavior? _____

Please describe teacher's concerns. _____
_____

Did teachers in earlier grades have the same concerns? _____ Did they also have other concerns? _____

If yes, please describe _____

Has/does your child receive tutoring? _____
_____

Please name three academic goals that you would like for him/her to accomplish this year. _____

_____

_____

Please provide the following information regarding specialists who have evaluated him/her outside of school?

Type of Service Provider	**Agency/Provider Name**	**Agency/Provider COMPLETE address**	**Date(s) Seen**
Neurologist			
Psychiatrist			
Psychologist			
Eye Specialist			
Hearing Specialist			
Speech/Language Pathologist			
Occupational Therapist			
Physical Therapist			
Geneticist			
Children's Rehab Services			
Public Health Dept:			
Dept of Human Resources			
Other (specify)			
Other (specifiy)			
Other (specifiy)			

Physician Information

When did the client last have a physical examination? _____

Name of Pediatrician or Physician: _____

Address _____

Current Medications **Prescriber** **Dose** **Reason for medication**

_____

_____

Past Medications **Prescriber** **Dose** **Reason for medication** **When/why stopped?**

_____

_____

Have there been any previous psychological, psychiatric, neurological, CT, MRI, or EEG Evaluations?

Yes _____ No _____ If yes, please list type of evaluation and date of contact. _____

Please indicate your understanding of the results _____

_____

_____

Is she/he currently in counseling? _____ If so, what is the focus of treatment? _____

_____

Has she/he ever been in therapy? _____ If so, when? _____
What was the focus of treatment? _____

Has he/she ever been hospitalized or placed in residential treatment for mental health or behavioral problems?
____ If yes when? _____ For how long _____ Where _____
Reasons/ Recommendations _____
_____

Chief problems as you see them:	**When did the problems begin? (Age or date)**
1.	
2.	
3.	
4.	
5.	

Did a regression of skills or a loss of skills ever occur in the client's development? Yes _____ No _____
If yes, when did this regression/loss of skills occur? _____

If yes, please describe the regression/loss of skills _____

Since you first noticed the delay in his/her development, how has his/her development changed? _____
_____

What do you see as his/her strengths? _____
_____

Comments: (Please use other side if necessary) : _____
_____
_____
_____

Thank you so much for taking the time to complete these forms. The information that you provided gives us a better understanding of his/her needs.

_____ _____
Parent Signature Date Parent Signature Date