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New Client Questionnaire

		J				
Child's Preferred Name					Date of Birth	
Child's Full Legal Name				Se	Birthplace (city, state)	
Perso	on wh	no completed this questionnaire				
Refe	rred b	у				
Pedia	atricia	n or Primary Care Physician				
School Name					Grade	Main Teacher
Yes	No	Has your child ever had any of the following?	Yes	No		
		special preschool program or Head Start			summer school	
		Early Intervention Program			behavioral interventions	
		Early Childhood Special Education			disciplinary actions	
		IFSP (Individualized Family Service Plan)			in-school or out-of-school susp	ension
		Special Education			expulsion	
		IEP (Individualized Educational Program)			speech therapy or language ser	vices
		Section 504 Plan			occupational or physical therap	у
		FBA (Functional Behavioral Assessment)			any other school-related support	rt services
		BSP (Behavioral Support Plan)			tutoring or remedial services	
		Safety Plan			home-based services	
		repeated a grade or subject				
Desc	ribe:					

List any evaluations your child had at school or private practices, clinics, or agencies:

Describe this family (including religious beliefs, adoptions, separation or divorce dates, parenting time schedule, Other Home Address (if applicable) Occupation Highest Level of Education Completed	etc.).	Age
Other Home Address (if applicable) Occupation Highest Level of Education Completed	etc.).	
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Occupation Highest Level of Education Completed		
Occupation Highest Level of Education Completed		
	nder	Age
Describe this family (including religious beliefs, adoptions, separation or divorce dates, parenting time schedule,		
	etc.).	

Home(s): In the space(s) below, provide your child's home address(es) and list who else lives there (plus any pets).

Name	е	Relationship to	o Child		Dates or Years of Illness	Date or Year of Death
Yes	No	he pregnancy and delivery of your child. Were there any of the following?	Yes	No		
		"high-risk" pregnancy			induced labor	
		complications			planned or emergency Cae	esarian or C-section
		Rh+ or a blood transfusion			breech delivery (feet first)	
		low Apgar score jaundice			suction or forceps NICU (neonatal intensive of	vara unit\
		water broke more than 24 hours before delivery			anesthesia	are uring
		prolonged labor (longer than 4 hours)			seizures	
		Did your child breath or cry right away?			36124163	
		Were the mother and child discharged from the h	oonito		thor?	
Desc	ribe:	Tree of the method and office discharged nom the	юѕрпа	toge	errer?	
Desc	ribe:		iospita	toge	errer?	
Wher walk unde spea	n cou rstan k in s k, put	ld your child do the following? Age months d language ingle words tting two words together months months months	<u>ю</u>	•	cribe any concerns about de	velopmental milestones
Wher walk unde spea spea potty	rstank k in s k, put	Id your child do the following? Age months d language months ingle words months tting two words together months months Has your child had any of the following?	Yes	Desc	cribe any concerns about de	velopmental milestones
Wher walk unde spea spea potty Yes	rstank in sk, put	Id your child do the following? Age months d language months ingle words months tting two words together months months Has your child had any of the following? developmental delays	Yes	Desc No	cribe any concerns about de	
Wher walk unde spea spea potty Yes	rstank in sk, put	Id your child do the following? Months d language months ingle words months tting two words together months months Has your child had any of the following? developmental delays surgeries, operations or hospitalizations	Yes	No 🗆	cribe any concerns about de family move lived in a home with dome	stic violence or abuse
Wher walk unde spea spea potty Yes	rstank in sk, put	Id your child do the following? Months d language In months ingle words Months tting two words together Months Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness	Yes	No O	family move lived in a home with dome witnessed violence or abus	stic violence or abuse
Wher walk unde spea spea potty Yes	rstank in sk, put	Id your child do the following? Months d language months ingle words months tting two words together months months Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures	Yes	No O	family move lived in a home with dome witnessed violence or abuse	stic violence or abuse se
Wher walk unde spea spea potty Yes	rstank in sk, put	Id your child do the following? Months d language months ingle words months tting two words together months months Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures head injuries	Yes	No O	family move lived in a home with dome witnessed violence or abuse chiropractic services or materials.	stic violence or abuse se
Wher walk unde spea spea potty Yes	rstank in sk, put	Id your child do the following? Months d language months ingle words months tting two words together months months Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures head injuries chronic ear infections	Yes	No O	family move lived in a home with dome witnessed violence or abus physical or sexual abuse chiropractic services or manaturopath services	stic violence or abuse se assage therapy
Wher walk unde spea spea potty	rstank in sk, put	Id your child do the following? Months d language months ingle words months tting two words together months months Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures head injuries	Yes	No O	family move lived in a home with dome witnessed violence or abuse chiropractic services or materials.	stic violence or abuse se assage therapy

Describe:

Mother	Father	Sibling	Grandparent	Aunt/Uncle	1 st Cousir	ı H	ave your child's relatives had any of the following?		
						in	herited or medical conditions		
						la	nguage or learning disability		
						Α	DD or ADHD		
						Α	utism or Asperger's		
							ensory sensitivities		
							epression		
							nxiety, nervousness, or a nervous breakdown		
							sychosis or schizophrenia		
							ipolar		
							roblems with drugs or alcohol		
							rrests or trouble with the police		
							uicide or suicide attempts		
							nental hospitalization		
						tr	eatment for other mental conditions		
	f your ch Past N		nt and past med	dications, vitar	nins, herba Dose	ls, sı	upplements, or alternative medicines. Reason or Purpose		
		arrio					11000011 011 019000		
	U								
		-	sleep?	·	-				
			ned about any o	the following		No			
		r eating					electronics use		
		or tiredne					grades or school performance		
		or bladde					homework		
		ry sensitiv	rity				relationships with teachers		
							relationships with peers or friends at school		
		cal compla					refusing to go to school		
			or headaches				suspension or expulsion		
			r alcohol use						
What books, workshops, blogs, religious teachings, etc. have influenced your parenting style? What have you tried (e.g., other therapists, medications, or any "non-traditional" treatments)?									
What do you want to address in this consultation?									

What else should I know?