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New Client Questionnaire

Please complete and return ***before*** your scheduled appointment. This questionnaire provides historical information to assist me in a thorough evaluation or consultation. I see children of all ages with differing problems, so some questions may be irrelevant to your child. You may ignore questions that do not apply. This information is confidential and will be released only with a signed release of information, to satisfy health insurance requirements (if you use health insurance), or in situations in which the law makes exceptions to confidentiality. Thank you!

Your Child's Preferred Name | Gender | Date of Birth

Your Child's Full Legal Name | Sex Assigned at Birth | Birthplace (city, state)

Your Child's Race and Ethnicity

Person Who Completed This Questionnaire

Referred By

Pediatrician or Primary Care Physician

List all of your child's current and past medications, vitamins, herbals, supplements, or alternative medicines.

Current	Past	Name	Dose	Reason or Purpose
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

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

Please bring or attach copies of past evaluations, relevant school information, report cards, standardized test scores, etc.

Today's Date

Have you spoken to or met with your child's: ☐ teacher ☐ school counselor ☐ principal ☐ _____

How many problems at school did your child have each school year?

	no problems	some problems	a lot of problems	Name of School(s)
Daycare	☐	☐	☐	
4-year-old Preschool	☐	☐	☐	
Kindergarten	☐	☐	☐	
1st Grade	☐	☐	☐	
2nd Grade	☐	☐	☐	
3rd Grade	☐	☐	☐	
4th Grade	☐	☐	☐	
5th Grade	☐	☐	☐	
6th Grade	☐	☐	☐	
7th Grade	☐	☐	☐	
8th Grade	☐	☐	☐	
9th Grade	☐	☐	☐	
10th Grade	☐	☐	☐	
11th Grade	☐	☐	☐	
12th Grade	☐	☐	☐	

Describe any problems at school.

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 suspension
☐	☐	Special Education	☐	☐	out-of-school suspension
☐	☐	IEP (Individualized Educational Program)	☐	☐	expulsion
☐	☐	Section 504 Plan	☐	☐	speech therapy or language services
☐	☐	FBA (Functional Behavioral Assessment)	☐	☐	occupational or physical therapy
☐	☐	BSP (Behavioral Support Plan)	☐	☐	any other school-related support services
☐	☐	Safety Plan	☐	☐	tutoring or remedial services
☐	☐	repeated a grade or subject	☐	☐	home-based services

Describe any of the above marked yes.

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

Home Address

Name	Relationship to Your Child (mom, step-dad, half-sister, etc.)	Occupation or School	Highest Level of Education Completed or Current Grade in School	Gender	Age

Describe this family (including religious beliefs, adoptions, separation or divorce dates, parenting time schedule, etc.).

Other Home Address (if applicable)

Name	Relationship to Your Child (mom, step-dad, half-sister, etc.)	Occupation or School	Highest Level of Education Completed or Current Grade in School	Gender	Age

Describe this family (including religious beliefs, adoptions, separation or divorce dates, parenting time schedule, etc.).

List any close family or friends who have died or had a major illness within your child's lifetime.

Name	Relationship to Your Child	Dates or Years of Illness	Date or Year of Death

Was your child born at: ☐ home ☐ birthing center ☐ hospital ☐ _____ Was that the original plan? ☐ yes ☐ no

If your child was born at home, did the mother and child stay at home afterwards? ☐ yes ☐ no

If your child was not born at home, were the mother and child discharged together?

Did your child breath or cry right away? ☐ yes ☐ no

Yes	No	Were there any of the following?	Yes	No	
☐	☐	"high-risk" pregnancy	☐	☐	prolonged labor (longer than 4 hours)
☐	☐	complications	☐	☐	induced labor
☐	☐	born premature (less than 39 weeks in the womb)	☐	☐	planned or emergency Caesarian or C-section
☐	☐	low birth weight (less than 5 pounds, 8 ounces)	☐	☐	breech delivery (feet first)
☐	☐	Rh+ or a blood transfusion	☐	☐	suction or forceps
☐	☐	low Apgar score	☐	☐	NICU (neonatal intensive care unit)
☐	☐	jaundice	☐	☐	anesthesia
☐	☐	water broke more than 24 hours before delivery	☐	☐	seizures

Describe any of the above marked yes and any problems during the pregnancy, delivery, or first few days of your child's life.

When could your child do the following?	Age
walk, holding on to something	months
walk, without holding on to anything	months
understand "no"	months
say single words like "mama" or "dada"	months
speak, putting 2 or more words together	months
use a toilet consistently, during the day	years
stay dry overnight	years

Describe any concerns about developmental milestones.

Yes	No	Has your child had any of the following?	Yes	No	
☐	☐	developmental delays	☐	☐	medical conditions I should be aware of
☐	☐	surgeries, operations or hospitalizations	☐	☐	family move
☐	☐	serious illness	☐	☐	lived in a home with domestic violence or abuse
☐	☐	seizures	☐	☐	witnessed violence or abuse
☐	☐	head injuries	☐	☐	physical or sexual abuse
☐	☐	chronic ear infections	☐	☐	chiropractic services or massage therapy
☐	☐	allergies	☐	☐	naturopath services
☐	☐	weight loss	☐	☐	exemption from immunizations
☐	☐	weight gain	☐	☐	immunizations

Describe any physical health concerns.

Mother	Father	Sibling	Grandparent	Aunt/Uncle	1st Cousin	Have your child's relatives had any of the following?
☐	☐	☐	☐	☐	☐	inherited or medical conditions
☐	☐	☐	☐	☐	☐	language or learning disability
☐	☐	☐	☐	☐	☐	ADD or ADHD
☐	☐	☐	☐	☐	☐	Autism or Asperger's
☐	☐	☐	☐	☐	☐	sensory sensitivities
☐	☐	☐	☐	☐	☐	depression
☐	☐	☐	☐	☐	☐	anxiety, nervousness, or a nervous breakdown
☐	☐	☐	☐	☐	☐	psychosis or schizophrenia
☐	☐	☐	☐	☐	☐	bipolar
☐	☐	☐	☐	☐	☐	problems with drugs or alcohol
☐	☐	☐	☐	☐	☐	arrests or trouble with the police
☐	☐	☐	☐	☐	☐	suicide or suicide attempts
☐	☐	☐	☐	☐	☐	mental hospitalization
☐	☐	☐	☐	☐	☐	treatment for other mental conditions

How much does your child sleep? _____ hours per night

Yes	No	Are you concerned about any of the following?	Yes	No	
☐	☐	diet or eating	☐	☐	electronics use
☐	☐	sleep or tiredness	☐	☐	grades or school performance
☐	☐	bowel or bladder control	☐	☐	homework
☐	☐	sensory sensitivity	☐	☐	relationships with teachers
☐	☐	attention	☐	☐	relationships with peers or friends at school
☐	☐	physical complaints	☐	☐	refusing to go to school
☐	☐	stomachaches or headaches	☐	☐	arriving late to school (or class)
☐	☐	tobacco, drug or alcohol use	☐	☐	suspension or expulsion

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?