Parent Questionnaire

Client's (Child's) Preferred Name | Birthdate

Child's Full Legal Name

Sex Assigned at Birth | Gender | Pronouns

Child's Race and Ethnicity | Birthplace City and State

Primary Language Spoken at Home | Other Languages Spoken at Home

Cultural, Religious or Secular Beliefs or Affiliations

Person Completing This Questionnaire

Referred By

Pediatrician or Primary Care Provider | Group

Address, Website or Phone Number | Date of Last Physical Exam

Has your child ever been married? ☐ No ☐ Yes

List dates of any mental health treatment (or school counseling) your child has ever received.

List any evaluations your child had (at school, private practices, clinics, agencies, etc.).

Please send copies of past evaluations, relevant school information, report cards, standardized test scores, etc. *before the appointment*.

Today's Date

Full Legal Name of Parent 1 | Birthdate

Preferred Name | Gender | Pronouns

Address | City, State ZIP

email | Phone | Other Phone

Full Legal Name of Parent 2 | Birthdate

Preferred Name | Gender | Pronouns

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Emergency Contact 1 | Relationship to Your Child

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Emergency Contact 2 | Relationship to Your Child

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Telehealth Backup Contact (in case of tech issues) | Relationship to Your Child

email | Phone | Other Phone

Your Child's Address | City, State ZIP

Your Child's email | Phone | Other Phone

Length of Pregnancy _____ weeks

Length of Delivery _____ hours (from first labor pains to birth)

Mother's Age at Birth (of your child) _____ years

Your child's birth weight _____ pounds _____ ounces

Did your child's mother receive prenatal medical care? ☐ Yes ☐ No ☐ I don't know

During pregnancy, did your child's mother use:
☐ alcohol ☐ vaping or e-cigarettes
☐ tobacco (or other forms of nicotine) ☐ marijuana ☐ recreational or illicit drugs

List all prescription and over-the-counter medications used during pregnancy.

Did any of the following occur during pregnancy or delivery?

☐ diabetes or excessive weight gain (more than 30 pounds)
☐ preeclampsia or toxemia (high blood pressure)
☐ infection or serious illness or injury
☐ water broke more than 24 hours before delivery
☐ breech delivery (feet first)
☐ forceps or suction was used during delivery
☐ planned or emergency Caesarian or C-section
☐ medication given to ease labor pains**—if so, list medication(s) below**
☐ other problems**—please describe below**
☐ unusual bleeding
☐ Rh factor incompatibility
☐ frequent nausea or vomiting
☐ labor or delivery was induced
☐ labor (longer than 4 hours)

Did any of the following affect your child during delivery or within the first few days after birth?

☐ injured during delivery
☐ cardiopulmonary distress during delivery
☐ delivered with cord around neck
☐ had a low Apgar score
☐ had trouble breathing following delivery
☐ was given medications**—if so, list medications below**
☐ born with a congenital defect**—please describe below**
☐ was in the NICU (neonatal intensive care unit)**—please describe below**
☐ was in the hospital more than 7 days**—please describe below**
☐ needed oxygen
☐ was cyanotic (turned blue)
☐ was jaundiced (turned yellow)
☐ had an infection
☐ had seizures

When did your child start:

understanding "no" _____ months ☐ within normal range ☐ late

saying single words (like "mama" or "dada") _____ months ☐ within normal range ☐ late

speaking, putting 2 or more words together _____ months ☐ within normal range ☐ late

sitting without help _____ months ☐ within normal range ☐ late

crawling _____ months ☐ within normal range ☐ late

standing up, holding on to something _____ months ☐ within normal range ☐ late

walking, without holding on to anything _____ months ☐ within normal range ☐ late

using a toilet consistently, during the day _____ years ☐ Not Yet

staying dry overnight _____ years ☐ Not Yet

puberty (pubic hair; breast / testicle growth) _____ years ☐ Not Yet ☐ I'm not sure

having a period _____ years ☐ Not Yet ☐ I'm not sure ☐ N/A

Describe any concerns about developmental milestones.

Has your child ever had:

☐ asthma
☐ allergies
☐ diabetes, arthritis or other chronic illnesses
☐ epilepsy or seizure disorder
☐ febrile seizures
☐ chickenpox or other common childhood illnesses
☐ heart or blood pressure problems
☐ high fevers (over 103°F)
☐ broken bones
☐ severe cuts requiring stitches
☐ head injury
☐ loss of consciousness, dizziness or fainting spells
☐ lead exposure or poisoning
☐ surgery (or an operation)
☐ lengthy hospitalization
☐ speech or language problems
☐ frequent colds or chronic ear infections
☐ hearing difficulties
☐ eye or vision problems
☐ eyeglasses
☐ fine motor or handwriting problems
☐ gross motor difficulties (clumsiness)
☐ appetite problems (over- or under-eating)
☐ sleep problems (falling or staying asleep)
☐ wetting or soiling problems
☐ other health difficulties or serious illnesses**—please describe below**

How long does your child sleep per night? _____ hours

Does your child get enough sleep? ☐ Yes ☐ No ☐ I'm not sure

List all of your child's current medications, vitamins, herbs, supplements, or alternative medicines

Name	Dose	Reason or Purpose

Has your child ever tried:

- ☐ alcohol
- ☐ marijuana
- ☐ others' prescriptions
- ☐ their own prescriptions not as prescribed
- ☐ over-the-counter medications not as directed
- ☐ vaping or e-cigarettes
- ☐ tobacco (or other forms of nicotine)

List any other substances your child has ever tried.

Has your child ever experienced any of the following?

- ☐ being bullied or harassed at school or in the neighborhood
- ☐ family moved to another city or another part of town
- ☐ changed schools
- ☐ family financial struggles
- ☐ homelessness
- ☐ lived in a home with domestic violence
- ☐ witnessed violence or abuse
- ☐ abuse or neglect
- ☐ talking about suicide or wanting to be dead
- ☐ suicide attempt
- ☐ talking about seriously harming someone
- ☐ attempt to seriously harm someone
- ☐ running away from home
- ☐ approached for sex
- ☐ arrest(s) or involvement in juvenile justice
- ☐ illegal activities that were not caught
- ☐ self-harm or hurting oneself on purpose, usually without wanting to die (for example, cutting)
- ☐ any unusual or stressful events**—please describe below**

Does your child:

- ☐ have the ability to be trusted to care for a pet
- ☐ handle their personal finances (e.g., allowance)
- ☐ take responsibility for their personal hygiene

If not, why?

How many friends does your child have? _____

Does your child:
- ☐ prefer being with younger children
- ☐ prefer being with older children
- ☐ prefer being with adults
- ☐ have a best friend
- ☐ have a romantic companion (e.g., girlfriend or boyfriend)

List your child's sports, recreational, free-time, and work/employment activities and interests.

What do you enjoy doing with your child?

What are your child's strengths?

Does your child like school? ☐ Yes ☐ Mostly ☐ Sometimes ☐ No ☐ I'm not sure

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

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

	none	some	a lot	Name of School (without using abbreviations)
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.

Has your child ever had any of the following?

- ☐ Early Childhood Special Education (e.g., Early Intervention, IFSP)
- ☐ Disciplinary Actions (e.g., in-school suspension, out-of-school suspension, expulsion)
- ☐ FBA (Functional Behavioral Assessment), BSP (Behavioral Support Plan) or Safety Plan
- ☐ Section 504 Plan
- ☐ Special Education (e.g., IEP)
- ☐ Speech (or Language) Services
- ☐ any other school-related support services
- ☐ Occupational Therapy
- ☐ Summer School (e.g., Extended School Year)
- ☐ Tutoring (or Remedial Services)

Describe any of the above that you marked.

Home(s): Provide your child's primary home address and list who else lives there (plus any pets).
If your child has another home, provide information about that home on the next page.

Home Address | City | State | ZIP

Age	Pronouns (he, she, they) (or Gender)	Name	Relationship to Your Child (mom, step-dad, half-sister)	Occupation or Grade in School

Describe this family's cultural, religious, or secular beliefs or affiliations.

List adoptions, separation or divorce dates, parenting schedules, and any other major changes.

List this family's favorite activities.

How frequently does your child see grandparents?

Who cares for the child(ren) when parents are at work or gone?

Home Address **(if applicable)**	City	State	ZIP

Age	(he, she, they) **Pronouns (or Gender)**	Name	(mom, step-dad, half-sister) **Relationship to Your Child**	**Occupation or Grade in School**

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Who cares for the child(ren) when parents are at work or gone?

Does your child's parents, siblings, grandparents, or parent's siblings have any of the following?
If so, specify the relationship to your child (e.g., dad's sister, mom's brother) in the space on the right.

- ☐ inherited medical conditions
- ☐ language or learning disability
- ☐ ADD or ADHD
- ☐ Autism, Asperger's, or a developmental problem
- ☐ depression or an emotional problem
- ☐ anxiety, nervousness, or a nervous breakdown
- ☐ bipolar, schizophrenia or psychosis
- ☐ diabetes
- ☐ eating disorder
- ☐ seizures or epilepsy
- ☐ problems with drugs or alcohol
- ☐ arrests, violence toward others, trouble with the police, or criminal involvement
- ☐ accused of child abuse or neglect
- ☐ suicide or suicide attempts
- ☐ mental hospitalization
- ☐ treatment for other mental conditions

In the space below, provide any relevant details.

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

Name	Relationship to Your Child	Years of Illness & Date/Year of Death

Have there been recent changes in your child's:

- ☐ sleep
- ☐ screen-time
- ☐ interests
- ☐ diet
- ☐ activities
- ☐ reading
- ☐ appetite
- ☐ hobbies

What books, workshops, blogs, religious teachings, etc. influence your parenting style?

What are you concerned about with your child?

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?