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Questionnaire

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 or add additional details on the last page.

Client's (Child's) Preferred Name | Preferred Pronouns | Gender

Child's Full Legal Name | Birthdate | Birth Sex

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 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

Was your child born at: ☐ home ☐ hospital ☐ _____

Did the mother and child stay at home afterwards? ☐ yes ☐ no

Were the mother and child discharged together? ☐ yes ☐ no

Was that the original plan? ☐ yes ☐ no

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	☐	☐	use of suction or forceps
☐	☐	low Apgar score	☐	☐	NICU (neonatal intensive care unit) services
☐	☐	jaundice	☐	☐	use of 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	Typical Age	Later than Typical
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.

How many hours does your child sleep per night? _____ Does your child get enough sleep? ☐ Yes ☐ No ☐ I'm not sure

Yes	No	Has your child ever had any of the following?	Yes	No	
☐	☐	developmental delays	☐	☐	family move
☐	☐	surgeries, operations or hospitalizations	☐	☐	lived in a home with domestic violence or abuse
☐	☐	serious illness	☐	☐	witnessed violence or abuse
☐	☐	seizures	☐	☐	physical or sexual abuse
☐	☐	head injuries	☐	☐	spanked or punished too hard
☐	☐	chronic ear infections	☐	☐	talking about suicide or wanting to be dead
☐	☐	allergies	☐	☐	suicide attempt
☐	☐	weight loss	☐	☐	talking about seriously harming someone else
☐	☐	weight gain	☐	☐	attempt to seriously harm someone else
☐	☐	delayed or skipped a childhood immunization	☐	☐	running away from home
☐	☐	exemption from immunizations	☐	☐	approached for sex
☐	☐	medical conditions I should be aware of	☐	☐	arrest(s) or involvement in juvenile justice
☐	☐	chiropractic services or massage therapy	☐	☐	illegal activities that were not caught
☐	☐	naturopath services			

Describe any of the above marked yes.

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

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?

	none	some	a lot	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): Provide your child's home address(es) and list who else lives there (plus any pets).

Home Address

Name	(mom, step-dad, half-sister) Relationship to Your Child	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.).

Home Address
(if applicable)

Name	(mom, step-dad, half-sister) Relationship to Your Child	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.).

Parent	Sibling	Grandparent	(Aunt/Uncle) Parent's Sibling	Other Extended Family	Have your child's relatives ever 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, trouble with the police, or criminal involvement
☐	☐	☐	☐	☐	suicide or suicide attempts
☐	☐	☐	☐	☐	mental hospitalization
☐	☐	☐	☐	☐	treatment for other mental conditions

Have there been recent changes in your child's: ☐ sleep ☐ appetite ☐ diet ☐ interests ☐ activities ☐ screen-time ☐ hobbies ☐ reading

Has your child tried: ☐ alcohol ☐ tobacco ☐ marijuana ☐ other's prescriptions ☐ their own prescriptions not as prescribed
List any other substances.

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?