

## 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

## Contact Information

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Full Legal Name of Parent 1	Birthdate
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Preferred Name	Gender	Pronouns
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Address	City, State ZIP
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email	Phone	Other Phone
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Full Legal Name of Parent 2	Birthdate
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Preferred Name	Gender	Pronouns
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Address	City, State ZIP
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email	Phone	Other Phone
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Full Name of Emergency Contact 1	Relationship to Your Child
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Address	City, State ZIP
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email	Phone	Other Phone
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Full Name of Emergency Contact 2	Relationship to Your Child
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Address	City, State ZIP
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email	Phone	Other Phone
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Full Name of Telehealth Backup Contact (in case of tech issues)	Relationship to Your Child
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email	Phone	Other Phone
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Your Child's Address	City, State ZIP
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Your Child's email	Phone	Other Phone
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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?

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

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

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

**When did your child start:**

understanding "no" \_\_\_\_\_ months

saying single words (like "mama" or "dada") \_\_\_\_\_ months

speaking, putting 2 or more words together \_\_\_\_\_ months

sitting without help \_\_\_\_\_ months

crawling \_\_\_\_\_ months

standing up, holding on to something \_\_\_\_\_ months

walking, without holding on to anything \_\_\_\_\_ months

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

staying dry overnight \_\_\_\_\_ years ☐ Not Yet

puberty \_\_\_\_\_ 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:**

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

**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
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Has your child ever tried:

- |   |   |
|---|---|
| <input type="checkbox"/> alcohol                                      | <input type="checkbox"/> vaping or e-cigarettes               |
| <input type="checkbox"/> marijuana                                    | <input type="checkbox"/> tobacco (or other forms of nicotine) |
| <input type="checkbox"/> others' prescriptions                        |   |
| <input type="checkbox"/> their own prescriptions not as prescribed    |   |
| <input type="checkbox"/> over-the-counter medications not as directed |   |

List any other substances your child has ever tried.

Has your child ever experienced any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> being bullied or harassed at school or in the neighborhood                                     |   |
| <input type="checkbox"/> family moved to another city or another part of town   |   |
| <input type="checkbox"/> changed schools  |   |
| <input type="checkbox"/> family financial struggles   | <input type="checkbox"/> talking about seriously harming someone      |
| <input type="checkbox"/> homelessness   | <input type="checkbox"/> attempt to seriously harm someone            |
| <input type="checkbox"/> lived in a home with domestic violence   | <input type="checkbox"/> running away from home                       |
| <input type="checkbox"/> witnessed violence or abuse  | <input type="checkbox"/> approached for sex                           |
| <input type="checkbox"/> abuse or neglect   | <input type="checkbox"/> arrest(s) or involvement in juvenile justice |
| <input type="checkbox"/> talking about suicide or wanting to be dead  | <input type="checkbox"/> illegal activities that were not caught      |
| <input type="checkbox"/> suicide attempt  |   |
| <input type="checkbox"/> self-harm or hurting oneself on purpose, usually without wanting to die (for example, cutting) |   |
| <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4-year-old Preschool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kindergarten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
1 <sup>st</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2 <sup>nd</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3 <sup>rd</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12 <sup>th</sup> Grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Describe any problems at school.

Has your child ever had any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Early Childhood Special Education (e.g., Early Intervention, IFSP)                     |   |
| <input type="checkbox"/> Disciplinary Actions (e.g., in-school suspension, out-of-school suspension, expulsion) |   |
| <input type="checkbox"/> FBA (Functional Behavioral Assessment), BSP (Behavioral Support Plan) or Safety Plan   |   |
| <input type="checkbox"/> Section 504 Plan   |   |
| <input type="checkbox"/> Special Education (e.g., IEP)  | <input type="checkbox"/> Occupational Therapy                       |
| <input type="checkbox"/> Speech (or Language) Services  | <input type="checkbox"/> Summer School (e.g., Extended School Year) |
| <input type="checkbox"/> any other school-related support services  | <input type="checkbox"/> 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
(he, she, they)	(mom, step-dad, half-sister)		
Pronouns	Relationship to	Occupation or	
Age (or Gender)	Your Child	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
(he, she, they) <b>Pronouns</b>		(mom, step-dad, half-sister) <b>Relationship to</b>		<b>Occupation or</b>
<b>Age</b>	<b>(or Gender)</b>	<b>Name</b>	<b>Your Child</b>	<b>Grade in School</b>


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?

**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.

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


## Presenting Problems

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?**