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New Client Questionnaire

Child's Preferred Name | Gender | Date of Birth

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

Person who completed this questionnaire

Referred by

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

Describe:

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, etc.

Today's Date

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 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.).

Other Home Address (if applicable)

Name	Relationship to 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.).

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

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

Describe the pregnancy and delivery of your child.

Yes	No	Were there any of the following?	Yes	No	
☐	☐	"high-risk" pregnancy	☐	☐	induced labor
☐	☐	complications	☐	☐	planned or emergency Caesarian or C-section
☐	☐	Rh+ or a blood transfusion	☐	☐	breech delivery (feet first)
☐	☐	low Apgar score	☐	☐	suction or forceps
☐	☐	jaundice	☐	☐	NICU (neonatal intensive care unit)
☐	☐	water broke more than 24 hours before delivery	☐	☐	anesthesia
☐	☐	prolonged labor (longer than 4 hours)	☐	☐	seizures
☐	☐	Did your child breath or cry right away?			
☐	☐	Were the mother and child discharged from the hospital together?			

Describe:

When could your child do the following?	Age
walk	months
understand language	months
speak in single words	months
speak, putting two words together	months
potty	months

Describe any concerns about developmental milestones.

Yes	No	Has your child 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	☐	☐	chiropractic services or massage therapy
☐	☐	chronic ear infections	☐	☐	naturopath services
☐	☐	allergies	☐	☐	exemption from immunizations
☐	☐	weight loss or gain	☐	☐	immunizations
☐	☐	medical conditions I should be aware of			

Describe:

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

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

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

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	☐	☐	suspension or expulsion
☐	☐	tobacco, drug or 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?