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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.

Your Child's Preferred Name | Preferred Pronouns | Gender

Full Legal Name | Birthdate | Birth Sex

Race and Ethnicity | Birthplace (city, state)

Religious or Secular Beliefs or Affiliations

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

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?
If your child was not born at home, were the mother and child discharged together? ☐ 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)**: 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 |
|---|---|---|---|---|---|
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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 |
|---|---|---|---|---|---|
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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?