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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.

Preferred Pronouns	Gender
Birthdate	Birth Sex
	Birthplace (city, state)
	()
pals, supplements, or alternative r	medicines.
e	Reason or Purpose

Was your child born at: □ home □ birthing center □ hospital	0_		Was that the ori	ginal plan? □ yes □ no
If your child was born at home, did the mother and child stay at h If your child was not born at home, were the mother and child dis				
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 t	han 4 hours)
□ □ complications			induced labor	
 □ born premature (less than 39 weeks in the womb) □ low birth weight (less than 5 pounds, 8 ounces) □ Rh+ or a blood transfusion 			planned or emergency C	aesarian 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	
	pical Age	Late	r than Desc	ribe any concerns about velopmental milestones.
				velopinentai milestones.
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How many hours does your child sleep per night? Does Yes No Has your child ever had any of the following? □ □ developmental delays	s your Yes	child No	l get enough sleep? ☐ Ye family move	s □ No □ I'm not sure
□ □ surgeries, operations or hospitalizations			lived in a home with dom	estic violence or abuse
□ □ serious illness			witnessed violence or ab	
□ □ seizures			physical or sexual abuse	
□ □ head injuries			spanked or punished too	
□ □ chronic ear infections			talking about suicide or v	
□ □ allergies			suicide attempt	<u> </u>
□ □ weight loss			talking about seriously ha	arming someone else
□ □ weight gain			attempt to seriously harn	_
□ □ 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	n 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 illr Name Relationship to Your			your child's lifetime. lates or Years of Illness	Date or Year of Death
Tiolationship to Tour	. 511110		according to the control of the cont	Date of Tour of Death

Have you spoken to d	or met v	with your	child's	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						
1 st Grade						
2 nd Grade						
3 rd Grade						
4 th Grade						
5 th Grade						
6 th Grade						
7 th Grade						
8 th Grade						
9 th Grade						
10 th Grade						
11 th Grade						
12 th Grade						
Describe any problem	ns at sc	hool.				

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	s(es) and list who else lives there (plus an	y pets).	
Home Address	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
Tano	(mom, step dad, man sister, etc.)	01 0011001	or ouriont grade in concer	Goridor	, igc
Describe this family (inc	cluding religious beliefs, adop	tions, separati	on or divorce dates, parenting time sched	dule, etc.).	
Other Home Address (if applicable)	Relationship to Your Child	Occupation	Highest Level of Education Completed		
Name	(mom, step-dad, half-sister, etc.)	or School	or Current Grade in School	Gender	Age
December 46's feed 9 / 0	alicalia a callada ca la cilada	Blanca and a	on or divorce dates, parenting time scheo	dada ata N	

Mother	Father	Sibling	Grandparent	Aunt/Uncle	1 st Cousin	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		
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 ha	ve you t	ried (e.g.,	, other therapis	ts, medicatior	ns, or any "n	on-traditional" treatments)?		
What do) you wa	nt to add	ress in this con	sultation?				

What else should I know?