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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 Affilia	ations
Person Completing This Questionnaire	
Referred By	
Pediatrician or Primary Care Physician	Group
Address, Website or Phone Number	Date of Last Physical Exam
Is your child ever been married? ☐ Yes ☐	⊃ No
List dates of any mental health treatment	(or school counseling) your child has ever received.
List any evaluations your child had (at sch	nool, private practices, clinics, agencies, etc.).
Please send copies of past evaluations, re report cards, standardized test scores, et	

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

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 have: □ alcohol □ vaping or e-cigarettes □ marijuana □ tobacco (or other forms of nicotine) □ 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 unusual bleeding diabetes or excessive weight gain (more than 30 pounds preeclampsia or toxemia (high blood pressure) Rh factor incompatibility infection or serious illness or injury frequent nausea or vomiting medication given to ease labor pains—if so, name of prolonged labor (longer than 4 hours) water broke more than 24 hours before delivery labor or delivery was induced forceps or suction was used during delivery breech delivery (feet first) planned or emergency Caesarian or C-section other problems—please describe	nds)
Did any of the following affect your child during delivery	e describe

When did your child start: understanding "no" _	mor	_	cribe any conce levelopmental m	
saying single words (like "mama" or "dada")				
speaking, putting 2 or more words together _				
sitting without help _	mor	tns		
crawling _	mor	ths		
standing up, holding on to something $$	mor	ths		
walking, without holding on to anything $$	mor	ths		
using a toilet consistently, during the day _	year	s □ Not Yet		
staying dry overnight _	year	s □ Not Yet		
puberty _	year	s □ Not Yet	☐ I'm not sure	
having a period _	year	s □ Not Yet	☐ I'm not sure	□ N/A
Has your child ever had:	•			
□ asthma				
□ allergies				
☐ diabetes, arthritis or other chronic illness	es			
□ epilepsy or seizure disorder				
☐ febrile seizures				
☐ chickenpox or other common childhood	illnesses			
\square heart or blood pressure problems				
☐ high fevers (over 103°F)				
□ broken bones				
□ severe cuts requiring stitches				
☐ head injury, loss of consciousness, dizzi	ness or fainting spe	ells		
☐ lead exposure or poisoning				
□ surgery (or an operation)				
☐ lengthy hospitalization				
☐ speech or language problems				
☐ frequent colds or chronic ear infections				
□ hearing difficulties				
□ eye or vision problems				
□ eyeglasses				
☐ fine motor or handwriting problems				
gross motor difficulties (clumsiness)				
appetite problems (overeating or undere				
□ sleep problems (falling asleep, staying as	sleep)			
□ soiling problems				
□ wetting problems				
other health difficulties or serious illnesse	es –please descri	be		

How long does your child	sleep per night? hours	
Does your child ge	et enough sleep? □ Yes □ No □ I'm not sur	re
List all of your child's cur	rent medications, vitamins, herbs, supplem	ents, or alternative medicines.
Name	Dose	Reason or Purpose
Lice years abild ever tried.		Lint any other authorone
Has your child ever tried: ☐ alcohol	□ vaping or e-cigarettes	List any other substances your child has ever tried.
□ marijuana	☐ tobacco (or other forms of nicotine)	•
☐ others' prescriptions	i tobacco (of other forms of mootine)	
☐ their own prescription	ns not as prescribed	
·	dications not as directed	
	rienced any of the following?	
☐ family moved to anote ☐ changed schools ☐ being bullied or haras ☐ family financial strugged in a home with ☐ witnessed violence of ☐ abuse (or neglect) ☐ talking about suicide ☐ suicide attempt ☐ talking about serious ☐ attempt to seriously ☐ running away from he ☐ approached for sex ☐ arrest(s) or involvemed ☐ illegal activities that we involve ☐ approached for sex ☐ arrest(s) or involvemed ☐ illegal activities that we involve ☐ approached for sex ☐ arrest(s) or involvemed ☐ arrest(s) or invol	ther city or another part of town ssed at school or in the neighborhood gles domestic violence or abuse or wanting to be dead ly harming someone harm someone ome ent in juvenile justice	
Does your child:		If not, why?
	trusted to care for a pet	,,
	I finances (e.g., allowance)	
•	r their personal hygiene	

Developmental and Health History

Does your child:	How many friends does your child have?
□ prefer being with younger children	
□ prefer being with older children	
□ prefer being with adults	
☐ have a best friend	
☐ have a romantic companion (e.g., girlf	riend 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?	

How many academic	or ber	navior pr	oblems	s did your child have at school each school year?	Describe any problems at school.
	none	some	a lot	Name of School (without using abbreviations)	
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					
Does your child like	school'	? □ Yes	□ Mos	stly □ Sometimes □ No □ I'm not sure	
Have you spoken to	or met	with you	ır child	's: □ teacher □ school counselor □ principal	
Has your child ever I	nad any	of the f	ollowin	g?	
☐ Speech (or Lan	guage) :	Services		☐ Early Childhood Special Education (e.g., Ea	arly Intervention, IFSP)
□ Occupational T	herapy			☐ Summer School (e.g., Extended School Ye	ar)
□ Tutoring (or Rer	medial S	Services)		☐ FBA (Functional Behavioral Assessment), E	3SP (Behavioral Support Plan) or Safety Plan
☐ Section 504 Pla	เท			☐ Disciplinary Actions (e.g., in-school susper	sion, out-of-school suspension, expulsion)
☐ Special Educati	ion (e.g.	, IEP)		☐ any other school-related support services	
Describe any of the	above t	hat you	marked	d.	

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
Name	(mom, step-dad, half-sister) Relationship to Your Child	Children: School & Current Grade Adults: Occupation & Highest Level of Ed	ucation Gender	(he, she, they) Pronouns	
	·	, , , , , , , , , , , , , , , , , , ,			
Describe this family's	s cultural, religious or secular belief		ptions, separation parenting t other major cha	ime schedule	, and
List this family's favo	rite activities.				
How frequently does	your child see grandparents?				
Who cares for the ch	ild(ren) when parents are at work o	r gone?			

Home Address (if applicable)		City		State		ZIP
(ii applicable)	(mom, step-dad, half-sister)	Children: School & Current Grade			(he, she, they)	
Name	Relationship to Your Child	Adults: Occupation & Highest L		Gender	Pronouns	Age
Describe this family's	s cultural, religious or secular belief	s or affiliations.		enting tim	e schedule,	, and
			any other ma	ijor chang	jes in the fa	mıly.
List this family's favo	rite activities.					
How frequently does	your child see grandparents from t	his family?				
Who cares for the chi	ild(ren) when parents are at work o	r gone?				

(Aunt/Uncle) Parent's Sibling	Grandparent	Sibling	Parent	Have your child's relatives ever had any of the following?
				inherited medical conditions
				language or learning disability
				ADD or ADHD
				Autism, Asperger's, or a developmental problem
				depression or an emotional problem
				anxiety, nervousness, or a nervous breakdown
				bipolar, schizophrenia or psychosis
				diabetes
				eating disorder
				seizures or epilepsy
				problems with drugs or alcohol
				arrests, violence toward others, trouble with the police, or criminal involvement
				accused of child abuse or neglect
				suicide or suicide attempts
				mental hospitalization
				treatment for other mental conditions

On the lines above, describe the relationship to the child (e.g., mom, dad's dad, etc.). In the space below, provide any relevant details.

List any close family, mends, or pers who have died of had a major limess within your child's medine.							
Name	Relationship to Your Child	Dates or Years of Illness	Date or Year of Death				

Presenting Problems

Have there been recent changes in your child's:	□ sleep □ diet □ appetite	□ screen-time□ activities□ hobbies	□ interests □ reading
What books, workshops, blogs, religious teaching	ngs, etc. influence y	your parenting style?	?
What are you concerned about with your child?			
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What have you tried (e.g., other therapists, medical	cations, or any "no	n-traditional" treatm	ients)?
What do you want to address in this consultation	1?		

What else should I know?