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New Client Questionnaire

Please complete and return *before* your scheduled appointment. This questionnaire provides historical information to assist me in a thorough evaluation or consultation. 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. This information is confidential and will be released only with a signed release of information, to satisfy health insurance requirements (if you use health insurance), or in situations in which the law makes exceptions to confidentiality. Thank you!

Your Ch	ild's Preferred Name	Gender	Date of Birth Birthplace (city, state)	
Your Ch	ild's Full Legal Name	Sex Assigned at Birth		
Person \	Who Completed This Questionnaire			
Referred	I By			
Pediatrio	cian or Primary Care Physician			
		ations, vitamins, herbals, supplements, or alternative me		
Current	Past Name	Dose	Reason or Purpose	
	0			
	0			
	0			
		or private practices, clinics, or agencies.		
	oring or attach copies of past evaluation		Todav's Da	

Have you spoken to o	or met with	n your child	's: □teach	ner 🗆 school counselor	r □ principal □			
How many problems at school did your child have each school year?								
	no problems	some	a lot of	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 schoo	ol.						

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 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
Describe this family	(including religious beliefs, adop	tions, separati	ion or divorce dates, parenting time sched	dule, etc.).	
Other Home Addres		Occupation	Highest Level of Education Completed		
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
Departing this face 9	, (in all all an unline or beliefe en le	Name and the		dl.a4 \	
Describe this family	r (including religious beliets, adop	nions, separati	ion or divorce dates, parenting time sched	uuie, etc.).	

Home(s): In the space(s) below, provide your child's home address(es) and list who else lives there (plus any pets).

Nam	e	Relations	hip to Your C	hild	Dates or Years of Illness	Date or Year of Death
If you	ur child ur child our ch	child born at: home birthing center dwas born at home, did the mother and ched was not born at home, were the mother and breath or cry right away? yes no	ild stay at ho and child disc	me aft	erwards?	ginal plan? □ yes □ no
Yes		Were there any of the following?	Yes			
		"high-risk" pregnancy			prolonged labor (longer that	an 4 hours)
		complications			induced labor	
		born premature (less than 39 weeks in the			planned or emergency Cae	esarian or C-section
		low birth weight (less than 5 pounds, 8 or	· · · · · · · · · · · · · · · · · · ·		breech delivery (feet first)	
		Rh+ or a blood transfusion			suction or forceps	
		low Apgar score			NICU (neonatal intensive of	are unit)
		jaundice water broke more than 24 hours before d	eliverv 🗆		anesthesia seizures	
Desc	ribe ar	ny of the above marked yes and any prob	lems during t	ne pre	gnancy, delivery, or first few	days of your child's life.
When	n could	d your child do the following?	Age		gnancy, delivery, or first few cribe any concerns about de	
Whei walk	n coulc	d your child do the following? ng on to something mo	Age nths			
When walk	n could holdir	d your child do the following? ng on to something mo out holding on to anything mo	Age nths nths			
When walk, walk, unde	n could holdir witho	d your child do the following? ng on to something mo out holding on to anything mo d "no" mo	Age nths nths			
When walk, walk, under say s	n could holdir witho rstand ingle v	d your child do the following? ng on to something mo out holding on to anything mo d "no" mo words like "mama" or "dada" mo	Age nths nths nths nths			
When walk, walk, under say s	n could holdir witho rstand ingle v k, putt	d your child do the following? ng on to something mo but holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo	Age nths nths nths nths nths nths			
When walk walk unde say s spea use a	n could holdir witho rstand ingle v k, putt a toilet	d your child do the following? ng on to something mo but holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y	Age nths nths nths nths nths ears			
When walk walk unde say s spea use a	n could holdir witho rstand ingle v k, putt a toilet	d your child do the following? ng on to something mo but holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y	Age nths nths nths nths nths nths			
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Whele walk, walk, under say see a stay Yes	n could holdir witho rstand ingle v k, putt a toilet dry ove	d your child do the following? ng on to something mo out holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y ernight y Has your child had any of the following? developmental delays	Age nths nths nths nths ears ears	Desc s No	cribe any concerns about de	velopmental milestones.
Whele walk, walk, under says spear use a stay	n could holdir witho rstand single v k, putt a toilet dry ove	d your child do the following? ng on to something mo out holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y ernight y Has your child had any of the following? developmental delays surgeries, operations or hospitalizations	Age nths nths nths nths ears ears	Desc S No	cribe any concerns about de medical conditions I should	velopmental milestones.
When walk, under says spea use a stay	n could holdin withourstand hingle value atoilet dry over the could be coul	d your child do the following? ng on to something mo out holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y ernight y Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness	Age nths nths nths nths ears ears	Desc S No	medical conditions I shoul family move lived in a home with dome	velopmental milestones. d be aware of stic violence or abuse
When walk, walk, under says spearuse a stay	n could holdir witho rstand single v k, putt a toilet dry ove	d your child do the following? Ing on to something mo but holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y ernight y Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures	Age nths nths nths nths ears ears	Desc No	medical conditions I should family move lived in a home with dome witnessed violence or abuse.	velopmental milestones. d be aware of stic violence or abuse
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Whele walk, walk, under says spears astay Yes	n could holdin withourstand hingle value to let dry over the could be could	d your child do the following? ng on to something mo but holding on to anything mo d "no" mo words like "mama" or "dada" mo ting 2 or more words together mo consistently, during the day y ernight y Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures head injuries chronic ear infections	Age nths nths nths nths ears ears	Desc No	medical conditions I should family move lived in a home with dome witnessed violence or abuse chiropractic services or materials.	velopmental milestones. d be aware of stic violence or abuse se
Where walk, walk, under says speared use a stay	n could holdin withourstand hingle value to let dry over the could be could	d your child do the following? Ing on to something mo out holding on to anything mo out holding on to anything mo out may be a surple of the following of the following? Has your child had any of the following? developmental delays surgeries, operations or hospitalizations serious illness seizures head injuries	Age nths nths nths ears	Desc	medical conditions I should family move lived in a home with dome witnessed violence or abuse physical or sexual abuse	d be aware of stic violence or abuse se

Describe any physical health concerns.

Moth	er F	ather	Sibling	Grandparent	Aunt/Uncle	1 st Cousir	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
How Yes		-		sleep?		Ū	No
			eating	ca about any o	THE TOHOWING		electronics use
$\overline{}$			or tirednes	29			grades or school performance
$\overline{\Box}$			or bladde				homework
$\overline{\Box}$			ry sensitivi				□ relationships with teachers
		attenti	•	y			relationships with peers or friends at school
			al compla	ints			refusing to go to school
				r headaches			arriving late to school (or class)
				r alcohol use			uspension or expulsion
What	book				eachings, etc. I	nave influe	nced 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?