Cognitive Behavioral Solutions

Drs. Amy Assemany, Jennifer Holmberg & Kimberly Rubin

Parent Questionnaire

We encourage parents/caregivers to fill out this questionnaire together. Review the entire questionnaire before completing. As this questionnaire is used for a wide range of ages and disabilities some questions may not apply to your child and you may skip those. Different opinions may be indicated by different marks (or different color ink). If you have any questions or need assistance, please contact us.

Child's Name: _____ Today's Date: _____

Nickname if any: _____ Date of birth: _____ Age:_____ Sex: Male / Female

Person completing form: _____ Relationship to child _____

Parents' Names: _____

Child's Address: _____

Street_____City_____Phone: (_____) _____

State _____Zip code_____

Additional address (e.g.) Non-custodial parent):_____

Relationship to child _____

Street_____City_____ Phone: (_____) _____

State _____Zip code_____

Parents' work phones: Mother: (_____) _____ Father: (_____) _____

Parents' email (include only if you authorize communication by email):

Mother: _____Father: _____

Language(s) spoken at home: _____Interpreter needed? __No __Yes

Child's Primary Care Doctor: _____Phone: (_____) _____

Doctor's complete address:_____

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I. PRESENTING CONCERNS

Please list your main concerns about your child:_____

_____

_____

_____

_____

_____

_____

_____

When were problems first noticed? _____

_____

What have you tried to do about these problems in the past? _____

_____

Has your child ever been diagnosed with developmental delay, learning disability, autism, mood disorder or attention-deficit/hyperactivity disorder? NO YES Please specify._____

_____

What are your child's special qualities and strengths? _____

_____

_____

Why are you seeking help or evaluation at this time? _____

_____

Who wanted or suggested getting this evaluation?_____

Who suggested or referred you to my office? _____

What would you like to accomplish with this evaluation? _____

_____

_____

_____

Is there a specific evaluation that you are requesting? NO YES If yes, indicate which one(s)?

____ Psychological or emotional ____ IQ testing only ____ Comprehensive Psycho-educational testing

II. PREVIOUS EVALUATIONS AND TREATMENTS

Please indicate if your child has had any of the following: (Please attach any reports)

SCHOOL TESTING (special education evaluation, speech/language testing, etc.)?

Year	Grade	Type of Testing (IQ, Language, OT, PT, educational, etc...

OTHER EVALUATIONS including psychologist, neurologist or other specialist doctors?

Year	Professional's Name	Type of Testing

MEDICAL TESTS including EEG, MRI, Chromosome test, etc.?

Year	Type of Testing	Results

Has your child received private COUNSELING?

Therapist	Date Started	Date Stopped

Has your child had a PSYCHIATRIC or DRUG TREATMENT HOSPITALIZATION? NO YES

Place:_____ Dates:_____

Does your child receive Social Security Insurance (SSI) BENEFITS? NO YES REJECTED

Has your child or family received services or case management through an AGENCY? NO YES

(e.g., Dept. of Social Services, Police, Court system, Child Protective Services, Dept. of Mental Health, etc.)

Agency: _____ Service:_____

Agency: _____ Service:_____

Has your child taken MEDICATION for attention, behavior or emotional problems? NO YES

Medication	Dosage	Date	Date	Effects or Adverse Effects

III. HEALTH HISTORY

Is this child adopted? __ No __ Yes at age _____ from (country) _____

Pregnancy, Labor & Delivery History	No	Yes	Comments
1. Age of mother when child was born: _____ years			
2. Is this child a twin or multiple?			
3. Any problems with other pregnancies? Miscarriages?			
4. Were there any problems during this pregnancy?			
5. Amniocentesis or other fetal health tests?			
6. Any medications prescribed? Why?			
7. Gestational diabetes (sugar in urine)?			
8. Any problem with blood pressure or toxemia?			
9. Any problems with infections (including herpes)?			
10. Smoking during pregnancy? How many packs per day?			
11. Drank alcohol (beer, wine, etc) during pregnancy?			
12. Any drugs (marijuana, cocaine, etc.) taken?			
13. Any problems during labor or delivery?			
14. Cesarean delivery? Why?			
15. Baby was born at _____ weeks			

Newborn History	No	Yes	Comments
1. Birth weight? _____lbs. _____Oz.			
2. Were there any problems at birth or as a newborn?			
3. Were there any birth defects or birth injuries noted?			
4. Put in Special Care or Intensive Care Nursery? ___days			
5. Have jaundice and need phototherapy?			
6. Very jittery or lethargic as a newborn?			
7. Baby had to stay extra days in the hospital?			

Early Infancy

Describe your child as an infant or toddler _____

_____

_____

_____

_____

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Infant Temperament Problems	No	Yes	Comments
1. Problems with feeding in infancy?			
2. Severe or prolonged colic or excessive crying?			
3. Difficult temperament (irritable or demanding)?			
4. Excessively wiggly or active as infant or toddler?			
5. Easily over-stimulated as infant or toddler?			
6. Passive, shy or withdrawn as infant or toddler?			
7. Didn't like to be held or cuddled?			

Medical History	No	Yes	Age or Comments
1. Problems with vision? Crossed eyes? Wears glasses?			
2. Problems with hearing?			
3. Serious or chronic health problem (such as diabetes)?			
4. Birth defect or birthmarks?			
5. Hospitalizations or surgery?			
6. Serious infections or illness (e.g., meningitis)?			
7. Serious injury, burn or broken bones?			
8. Head injury or lost consciousness?			
9. Frequent accidents or multiple minor injuries?			
10. Fainting spells or dizziness?			
11. Seizures, convulsions or staring spells?			
12. Motor tics (blinking, squinting, head tossing)?			
13. Vocal tics (sniffing, grunting, throat clearing, noises)?			
14. Compulsive mannerisms (hand washing, picking,			
15. Frequent headaches? Migraines?			
16. Serious ear infections? Chronic antibiotics or ear tubes?			
17. Serious nose, mouth or throat problems?			
18. Thyroid disorders or other hormone problems?			
19. Respiratory or lung problems (pneumonia, asthma)?			
20. Too fast heart beat (palpitations) or chest pains?			
21. Frequent stomachaches?			
22. Problems with vomiting, diarrhea or constipation?			
23. Problems with kidneys, bladder or urine?			
24. Blood problems or anemia (iron deficiency or low blood			

Medical History	No	Yes	Age or Comments
25. Poisoning or exposure to toxic chemicals (e.g. lead)?			
26. Unusual reaction to immunization?			
27. History or suspicion of physical or sexual abuse?			
28. History or suspicion of tobacco, alcohol or drug use?			
29. Problems with restless sleep or snoring?			
30. Difficulties with eating, diet or appetite?			
31. Small for age or very underweight?			
32. Over eats or overweight?			
33. If female, has she had her period yet? Any problems?			
34. Allergies to medications? Specify.			
35. Other allergies? Specify.			
36. Any vitamin supplements? Specify.			
37. Any herbal medicines or other nutritional supplements?			
38. Any non-medical treatments (diet, chiropractic,			
39 Any prescribed medications? Please specify.			

IV. DEVELOPMENTAL HISTORY

Developmental Milestones	No	Yes	Too Young
1. Sit up by 8 months?			
2. Crawl by 10 months?			
3. Walk by 15 months? Age:____months			
4. Speak in 2 word sentences by 2 years?			
5. Could strangers understand your child by 3 years?			
6. Toilet trained during the day by 3 1/2 years?			
7. Dry at night by 5 years?			
8. Read simple words by 6 years?			

Developmental Disabilities	No	Yes	Too Young
1. Urine accidents? Daytime or night time wetting?			
2. Stool/bowel accidents (soiling)?			
3. Difficulty falling asleep or bedtime behavior?			
4. Difficulty staying asleep or staying in bed at night?			

Developmental Disabilities	No	Yes	Too Young
5. Difficulty waking up in the morning?			
6. Difficulty with self-care (feeding self, washing or toileting)?			
7. Difficulty with learning to button, zip or dress?			
8. Difficulty learning to throw and catch a ball?			
9. Difficulty learning to name colors or shapes?			
10. Difficulty learning to name letters or numbers?			
11. Difficulty learning to ride a tricycle or bicycle?			

Did your child seem to develop normally but then lose developmental skills? NO YES

If yes, describe _____

Current Developmental Skills	Above Average	Average	Below Average	Too Young
1. Ability to understand spoken words				
2. Pronounces words clearly				
3. Ability to talk and use good sentences				
4. Conversation skills (turn-taking; uses polite language)				
5. Ability to use fingers to write or draw				
6. Ability to use large muscles to run or play sports				

Comments on development or skills:_____

_____

_____

_____

V. SOCIAL DEVELOPMENT

Describe your child as a young child: _____

_____

What is your child's temperament or personality like now? _____

_____

_____

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How does your child get along with adult members of the family? _____

_____

How does your child get along with adults outside the family?_____

_____

How does your child get along with siblings? _____

_____

_____

How does your child get along with playmates/peers? _____

_____

_____

Child's activities and special interests (sports, classes, favorite activities): _____

_____

How much time per day does your child spend watching TV? _____

How much time per day does your child spend on computer/video games? _____

Do you own a computer? NO YES

Does your child use a computer for school work? NO SOMETIMES OFTEN

Does your child have Internet access? NO YES

Some children behave in unusual ways. Please review the following items and indicate if they describe your child's behavior.	**Not True**	**Somewhat True**	**Very True**
1. Poor eye contact			
2. Doesn't use gestures (pointing)			
3. Doesn't try to use words to communicate			
4. Echoes words or phrases			
5. Speaks in unusual tone or manner			
6. Hard to get child's attention			
7. Seems preoccupied, aloof or distant			
8. Repetitive behaviors (flaps hands, moves body or fingers in unusual ways)			
9. Prefers to be alone; ignores others			

10. Difficulty relating to peers or making friends			
11. Unusual play behaviors; little pretend play			
12. Has unusual or very intense interests			
13. Takes things too literally; misses the point			
14. Handles change poorly; insists on sameness			

VI. BEHAVIORAL HISTORY

Describe any concerns about your child's behavior _____

_____

_____

_____

How do you usually handle misbehavior? _____

_____

How does your child respond to being told "no" or being corrected for misbehaving?

_____

How often do you use physical punishment such as spanking?_____

_____

How does your child respond to praise, rewards or positive reinforcement? _____

_____

Do you and your spouse or partner agree on how to handle your child's behavior?

Usually Agree Sometimes Agree Often Disagree

Behavior Symptoms - A	**Never**	**Some-times**	**Often**	**Very Often**
1. Makes many careless errors				
2. Difficulty concentrating on difficult tasks				
3. Does not seem to listen when spoken to				
4. Doesn't finish tasks (such as schoolwork)				
5. Difficulty organizing tasks or belongings				
6. Avoids tasks that require concentration or effort				
7. Loses or misplaces things				

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Behavior Symptoms - A	Never	Some-times	Often	Very Often
8. Is easily distracted by unimportant things				
9. Is forgetful				
10. Fidgets with hands; squirms in seat				
11. Difficulty remaining seated when asked				
12. Runs or climbs when told not to				
13. Has difficulty playing quietly				
14. Is “on the go”; Acts like “driven by a motor”				
15. Talks excessively				
16. Talks before thinking				
17. Difficulty awaiting turn in groups				
18. Interrupts (butts into conversations or games)				
19. Daydreams; “in his/her own world”, stares blankly				
20. Does things slowly				
21. Tries his/her best				

Behavior Symptoms - B	Never	Some-times	Often	Very Often
1. Is eager to please adults				
2. Loses temper				
3. Argues with adults				
4. Defies or refuses to do as asked				
5. Deliberately annoys others				
6. Blames other for own misbehavior or mistakes				
7. Is touchy or easily annoyed by others				
8. Is angry or resentful				
9. Tries to get even or takes out anger on others				
10. Is kind to others; has a “good heart”				
11. Does serious lying or cheating				
12. Bullies, threatens or intimidates others				
13. Starts physical fights				
14. Steals things				

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Behavior Symptoms - B	Never	Some-times	Often	Very Often
15. Deliberately destroys others' property				
16. Deliberately starts fires				
17. Uses a weapon when fighting (rock, stick, etc.)				
18. Is mean or physically cruel to people				
19. Is mean or physically cruel to animals				
20. Is preoccupied with or involved in sexual activity				
Behavior Symptoms - C	**Never**	**Some-times**	**Often**	**Very Often**
1. Is affectionate				
2. Unusually sensitive hearing or sense of smell				
3. Bothered by how things feel				
4. Over- or under-sensitive to pain				
5. Easily over-stimulated				
6. Unusual or limited diet				
7. Hurts herself/himself on purpose?				
8. History of eating things that are not food ("pica")?				
9. Has strange ideas (describe below)				
10. Unusual or strange behavior (describe below)				
11. Lacks awareness of danger?				
12. Excessive or public masturbation				
13. Excessive thumb-sucking or nail-biting				
14. Other habits (e.g. pulls out hair or lashes)				

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VII: EMOTIONAL HISTORY

Describe your child's usual mood_____

_____

Emotional Symptoms	Never	Some-times	Often	Very Often
1. Recovers easily from disappointments?				
2. Acts too young, seems "immature"?				
3. Over-reacts or easily upset?				
4. Irritable or easily angered?				
5. Is moody or has mood swings?				
6. Has temper tantrums?				
7. Has violent outbursts or prolonged rages?				
8. Cries a lot?				
9. Feels bad about self (low self-esteem)?				
10. Unhappy, sad or depressed?				
11. Low energy or tired for no reason?				
12. Talks about death or suicide?				
13. Enjoys many activities?				
14. Worried, nervous or anxious?				
15. Worries about leaving home or parents?				
16. Refuses to speak except to family members?				
17. Too concerned with neatness or cleanliness?				
18. Unusual habits? Has to do things a certain way?				
19. Frequent worries?				
20. Very self-conscious or easily embarrassed?				
21. Avoids going to school?				
22. Overly fearful? Specify:				

Stressful Life Experiences	No	Yes
1. Child had a very upsetting experience?		
2. Moved? Number of moves:_____		
3. Out of home placement (foster care, residential center)		
4. Family problems that may be bothering child?		
5. Divorce/separations/remarriage?		
6. Frequent arguments in home?		
7. Physical fights in home?		
8. Serious physical illness in parent, caregiver or sibling?		
9. Alcohol or substance abuse in immediate family member?		
10. Serious money or housing problems?		
11. Concerns about safety in neighborhood?		
12. Are there guns or other firearms in the house?		

VIII: HOME LIFE

Family Composition:

Child lives with: ____ Birth Mother ____ Birth Father ____ Stepmother ____ Stepfather ____Partner

____ Adoptive Mother ____ Adoptive Father ____ Foster Mother ____ Foster Father ____Guardian

____ Other Adult (e.g. grandparent or boyfriend) Specify:_____

Birth mother name: _____ Age:_____ Occupation:_____

Highest level of school completed:_____

Birth father name: _____ Age:_____ Occupation:_____

Highest level of school completed:_____

Adoptive/step/other mother name:_____ Occupation:_____

Highest level of school completed:_____

Adoptive/step/other father name: _____ Occupation:_____

Highest level of school completed:_____

Additional adults:_____

Parents' Marital Status: _____ Married _____ Never married _____ Separated / Divorced _____ Widowed

How do the child's parents get along with each other?

_____

_____

If separated/divorced, how long? _____

Contact with non-custodial parent or custody arrangements if any: _____

_____

Child care arrangements: _____

_____

What does your child do after school?_____

_____

Any special circumstances in the family situation? _____

_____

What does the family enjoy doing together?_____

_____

_____

Child's siblings or other children living IN the home:	**Full, half, adoption, step, etc.**	**Age**
Child's siblings or other children NOT living in the home:	**Full, half, adoption, step, etc.**	**Age**

Any concerns regarding sibling's health, development, learning or behavior?_____

_____

_____

IX. FAMILY HISTORY

Any difficult circumstances in MOTHER's childhood (e.g. abuse, alcoholic parents)?

_____

Any difficult circumstances in FATHER's childhood (e.g. abuse, alcoholic parents)?

_____

Any difficult circumstances in PARENT's childhood or background? _____

_____

Does anyone in the family have problems similar to this child's? If so who? _____

_____

Biological Family Medical and Psychiatric History (if adopted indicate information on any known biological relatives and indicate information on adoptive family members on lines below)

Any one in the child's biological family have:	**No**	**Yes**	**How this person related to child**
Attention problems/ADHD			
Behavior problems as child or teen			
Speech or language problems			
School problems			
Reading problems or Dyslexia			
Seizures or neurological problem			
Unusual drug reaction			
Mental Retardation			
Birth defect or genetic disorder			
Tics/Tourettes Syndrome			

Autistic spectrum disorder			
Thyroid problems			
Heart problems before age 50			
Physical or Sexual abuse			
Depression			
Bipolar / Manic depression			
Social problems/shyness			
Anxiety or Panic attacks			
Obsessive-compulsive Disorder			
Schizophrenia			
Alcohol problems			
Drug problems			
Trouble with the law			

Other problems that run in biological family:_____

_____

Psychiatric, behavioral or significant medical problems in step-, adoptive or foster family:

_____

X. SCHOOL HISTORY:

If this child is in preschool or school-aged, please answer the following questions.

Name of School:_____ School District: _____ State: ____

Main Teacher:_____ Principal: _____

Current Grade: _____ Length of time at this school: _____ School phone:_____

Placement, Programs and Services (now or in the past)	No	Yes	If Yes, when?
Early Intervention Program?			
Speech Therapy?			

Placement, Programs and Services (now or in the past)	No	Yes	If Yes, when?
Occupational Therapy?			
Physical Therapy?			
Repeated a grade? If yes, which grade(s)? _____			
Suspended from school?			
Failed or is failing a grade or subjects?			
Received any special education services?			
Placed in any special classes, program or school?			
Received resource room support or school-based tutoring?			
Received tutoring outside school?			
Received a Section 504 plan?			
Currently receiving any special education services?			
If yes, specify			

How satisfied are you with your child's current school placement and services?

Very Satisfied Somewhat satisfied Not satisfied

For each of the following grades completed, were any problems with academics or behavior reported? If Yes, please describe the teacher or parent concerns

	No	Yes	Academic or Behavioral Concerns
Preschool			
Kindergarten			
1st Grade			
2nd Grade			
3rd Grade			
4th-5th Grade			
6th - 8th Grade			

High School			

Describe child's strengths or strongest areas in school_____

_____

Current School Performance: Complete if child is five years or older

Subject	Above Average	Average	Below Average	Failing
Reading				
Understanding what he/she reads				
Spelling				
Handwriting				
Writing sentences or paragraphs				
Mathematics				
Word problems in math				
Social studies/History				
Science				
Art				
Music				
Gym				
Other:				

School-Related Behaviors	Not True	Some-times	Often True
1. Difficulty concentrating on work in school?			
2. Trouble sitting still in school?			
3. Rushes through work?			
4. Works too slowly?			
5. Calls out answers or interrupts in school?			
6. Disrupts class or distracts others?			
7. Needs a lot of repetition or explanations?			
8. Difficulty learning new material?			
9. Difficulty recalling what has learned?			

10. Low test grades?			
11. Problem with being organized?			
12. Forgets homework or books?			
13. Performance is up and down?			
14. Problem with starting on homework?			
15. Problem with finishing homework?			
16. Trouble with projects or long term assignments?			
17. Creative; has original ideas			

XI. Other information:

Please add any other information you feel may help us understand your child.

_____

_____

Thank you.