# 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 Affiliations

Person Completing This Questionnaire

Referred By

Pediatrician or Primary Care Provider | Group

Address, Website or Phone Number | Date of Last Physical Exam

**Has your child ever been married?** ☐ No ☐ Yes

**List dates of any mental health treatment (or school counseling) your child has ever received.**

**List any evaluations your child had (at school, private practices, clinics, agencies, etc.).**

**Please send copies of past evaluations, relevant school information, report cards, standardized test scores, etc. *before the appointment*.**

**Today's Date**

Full Legal Name of Parent 1 | Birthdate

Preferred Name | Gender | Pronouns

Address | City, State ZIP

email | Phone | Other Phone

Full Legal Name of Parent 2 | Birthdate

Preferred Name | Gender | Pronouns

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Emergency Contact 1 | Relationship to Your Child

Address | City, State ZIP

email | Phone | Other Phone

Full Name of Emergency Contact 2 | 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 use:**
☐ alcohol ☐ vaping or e-cigarettes
☐ tobacco (or other forms of nicotine) ☐ marijuana ☐ 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?**

☐ diabetes or excessive weight gain (more than 30 pounds)
☐ preeclampsia or toxemia (high blood pressure)
☐ infection or serious illness or injury
☐ water broke more than 24 hours before delivery
☐ breech delivery (feet first)
☐ forceps or suction was used during delivery
☐ planned or emergency Caesarian or C-section
☐ medication given to ease labor pains**—if so, list medication(s) below**
☐ other problems**—please describe below**
☐ unusual bleeding
☐ Rh factor incompatibility
☐ frequent nausea or vomiting
☐ labor or delivery was induced
☐ labor (longer than 4 hours)

**Did any of the following affect your child during delivery or within the first few days after birth?**

☐ injured during delivery
☐ cardiopulmonary distress during delivery
☐ delivered with cord around neck
☐ had a low Apgar score
☐ had trouble breathing following delivery
☐ was given medications**—if so, list medications below**
☐ born with a congenital defect**—please describe below**
☐ was in the NICU (neonatal intensive care unit)**—please describe below**
☐ was in the hospital more than 7 days**—please describe below**
☐ needed oxygen
☐ was cyanotic (turned blue)
☐ was jaundiced (turned yellow)
☐ had an infection
☐ had seizures

**When did your child start:**

understanding "no" _____ months

saying single words (like "mama" or "dada") _____ months

speaking, putting 2 or more words together _____ months

sitting without help _____ months

crawling _____ months

standing up, holding on to something _____ months

walking, without holding on to anything _____ months

using a toilet consistently, during the day _____ years ☐ Not Yet

staying dry overnight _____ years ☐ Not Yet

puberty _____ years ☐ Not Yet ☐ I'm not sure

having a period _____ years ☐ Not Yet ☐ I'm not sure ☐ N/A

**Describe any concerns about developmental milestones.**

**Has your child ever had:**

- ☐ asthma
- ☐ allergies
- ☐ diabetes, arthritis or other chronic illnesses
- ☐ epilepsy or seizure disorder
- ☐ febrile seizures
- ☐ chickenpox or other common childhood illnesses
- ☐ heart or blood pressure problems
- ☐ high fevers (over 103°F)
- ☐ broken bones
- ☐ severe cuts requiring stitches
- ☐ head injury
- ☐ loss of consciousness, dizziness or fainting spells
- ☐ 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 (over- or under-eating)
- ☐ sleep problems (falling or staying asleep)
- ☐ wetting or soiling problems
- ☐ other health difficulties or serious illnesses**—please describe below**

**How long does your child sleep per night?** _____ hours

**Does your child get enough sleep?** ☐ Yes ☐ No ☐ I'm not sure

**List all of your child's current medications, vitamins, herbs, supplements, or alternative medicines**

| Name | Dose | Reason or Purpose |
|---|---|---|
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**Has your child ever tried:**

- ☐ alcohol
- ☐ marijuana
- ☐ others' prescriptions
- ☐ their own prescriptions not as prescribed
- ☐ over-the-counter medications not as directed
- ☐ vaping or e-cigarettes
- ☐ tobacco (or other forms of nicotine)

**List any other substances your child has ever tried.**

**Has your child ever experienced any of the following?**

- ☐ being bullied or harassed at school or in the neighborhood
- ☐ family moved to another city or another part of town
- ☐ changed schools
- ☐ family financial struggles
- ☐ homelessness
- ☐ lived in a home with domestic violence
- ☐ witnessed violence or abuse
- ☐ abuse or neglect
- ☐ talking about suicide or wanting to be dead
- ☐ suicide attempt
- ☐ talking about seriously harming someone
- ☐ attempt to seriously harm someone
- ☐ running away from home
- ☐ approached for sex
- ☐ arrest(s) or involvement in juvenile justice
- ☐ illegal activities that were not caught
- ☐ self-harm or hurting oneself on purpose, usually without wanting to die (for example, cutting)
- ☐ any unusual or stressful events**—please describe below**

**Does your child:**

- ☐ have the ability to be trusted to care for a pet
- ☐ handle their personal finances (e.g., allowance)
- ☐ take responsibility for their personal hygiene

**If not, why?**

**How many friends does your child have?** _____

**Does your child:**
- ☐ prefer being with younger children
- ☐ prefer being with older children
- ☐ prefer being with adults
- ☐ have a best friend
- ☐ have a romantic companion (e.g., girlfriend 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?**

**Does your child like school?** ☐ Yes ☐ Mostly ☐ Sometimes ☐ No ☐ I'm not sure

**Have you spoken to or met with your child's:** ☐ teacher ☐ school counselor ☐ principal

**How many academic or behavior problems did your child have at school each school year?**

| | none | some | a lot | Name of School (without using abbreviations) |
|---|---|---|---|---|
| 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.**

**Has your child ever had any of the following?**

☐ Early Childhood Special Education (e.g., Early Intervention, IFSP)
☐ Disciplinary Actions (e.g., in-school suspension, out-of-school suspension, expulsion)
☐ FBA (Functional Behavioral Assessment), BSP (Behavioral Support Plan) or Safety Plan
☐ Section 504 Plan
☐ Special Education (e.g., IEP)
☐ Speech (or Language) Services
☐ any other school-related support services
☐ Occupational Therapy
☐ Summer School (e.g., Extended School Year)
☐ Tutoring (or Remedial Services)

**Describe any of the above that you marked.**

**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

| Age | Pronouns (he, she, they) (or Gender) | Name | Relationship to Your Child (mom, step-dad, half-sister) | Occupation or Grade in School |
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**Describe this family's cultural, religious, or secular beliefs or affiliations.**

**List adoptions, separation or divorce dates, parenting schedules, and any other major changes.**

**List this family's favorite activities.**

**How frequently does your child see grandparents?**

**Who cares for the child(ren) when parents are at work or gone?**

| Home Address **(if applicable)** | City | State | ZIP |
|---|---|---|---|
| | | | |

| Age | (he, she, they) **Pronouns (or Gender)** | Name | (mom, step-dad, half-sister) **Relationship to Your Child** | **Occupation or Grade in School** |
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**Describe this family's cultural, religious, or secular beliefs or affiliations.**

**List adoptions, separation or divorce dates, parenting schedules, and any other major changes.**

**List this family's favorite activities.**

**How frequently does your child see grandparents?**

**Who cares for the child(ren) when parents are at work or gone?**

**Does your child's parents, siblings, grandparents, or parent's siblings have any of the following?**
If so, specify the relationship to your child (e.g., dad's sister, mom's brother) in the space on the right.

- ☐ 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

**In the space below, provide any relevant details.**

**List any close family, friends, or pets who died or had a major illness within your child's lifetime.**

| Name | Relationship to Your Child | Years of Illness & Date/Year of Death |
|---|---|---|
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**Have there been recent changes in your child's:**

- ☐ sleep
- ☐ screen-time
- ☐ interests
- ☐ diet
- ☐ activities
- ☐ reading
- ☐ appetite
- ☐ hobbies

**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?**