

# PARENT QUESTIONNAIRE

The purpose of this informational survey is to provide an introduction to your family and especially to your child. Please complete the questionnaire as carefully as you can. Some of your child's information given here will be included in the written report at the discretion of Dr. Hill; please note if there's anything in particular that you wish to be held in confidence. The questions asked are not necessarily indicative of "trouble". Most questions are based upon the normal occurrences in the regular growth patterns of childhood. Please attach additional sheets for any detailed account you may wish to provide.

## Identifying Information

Child's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_  
                    First                      Middle                      Last                                      Mo / Day / Yr

Address \_\_\_\_\_ Age: \_\_\_\_\_  
                    Number/Street                      City                      Zip Code

Father's Name \_\_\_\_\_ Age: \_\_\_\_\_

Occupation/Field \_\_\_\_\_ Self-Employed: Yes No

Employer \_\_\_\_\_ Position: \_\_\_\_\_

Highest Academic Grade Completed: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Office \_\_\_\_\_ Mobile \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age: \_\_\_\_\_

Occupation/Field \_\_\_\_\_ Self-Employed: Yes No

Employer \_\_\_\_\_ Position: \_\_\_\_\_

Highest Academic Grade Completed: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Office \_\_\_\_\_ Mobile \_\_\_\_\_

Email: \_\_\_\_\_

### Divorced Parents:

Date of Divorce \_\_\_\_\_ Which parent is requesting this appointment for child? \_\_\_\_\_

Describe Custody Arrangements (sole, joint) \_\_\_\_\_

Give address of the noncustodial Parent \_\_\_\_\_

If Remarried, Date(s) of Remarriage(s) \_\_\_\_\_

With whom does child live? \_\_\_\_\_

Step-Parent Name(s) \_\_\_\_\_ Age: \_\_\_\_\_

Occupation \_\_\_\_\_ Self-Employed: Yes No

Employer \_\_\_\_\_ Position: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Office \_\_\_\_\_ Mobile \_\_\_\_\_

Person(s) living *in the home* with child:

	Name	Age	Legal Relationship
Mother	_____	_____	_____
Father	_____	_____	_____
Others	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Child's brothers and sisters living *outside the home*:

_____	_____	_____
_____	_____	_____

Other Languages Spoken fluently by Child: \_\_\_\_\_

Name of Child's School \_\_\_\_\_

Address \_\_\_\_\_ Telephone: \_\_\_\_\_

◇ Private School      ◇ Public, \_\_\_\_\_ Independent School District (Texas)

Current Grade \_\_\_\_\_ Teacher's Name \_\_\_\_\_ Contact Name \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

If child has been seen for previous evaluations and/or treatment (intervention), please provide the following information:

Name of Professional/Agency/School:      For Purpose Of (e.g. speech, OT, ADHD)      Year/Age Assessed or Treated

_____	_____	_____
_____	_____	_____

Please list any previous diagnoses: \_\_\_\_\_

Why did you bring your child for the current evaluation? Do you have a primary concern?

\_\_\_\_\_  
\_\_\_\_\_

What information do you expect to gain from this evaluation?

\_\_\_\_\_  
\_\_\_\_\_

**Reason for Referral**

- ◇ No concerns, but interested in learning profile
- ◇ Academic concerns (e.g. reading, math, auditory processing): Specify \_\_\_\_\_
- ◇ Attention concerns
- ◇ Emotional concerns
- ◇ Learning strategies
- ◇ School placement
- ◇ Obtaining services at school
- ◇ Obtaining private services (e.g. tutoring, counseling, etc.)
- ◇ Any additional concerns: \_\_\_\_\_

Child's pediatrician/physician \_\_\_\_\_

Have you discussed child's difficulties with this Doctor? ◇ Yes ◇ No \_\_\_\_\_

**PLEASE ✓ THE ANSWERS THAT MOST ACCURATELY APPLY**

**History**

***Pregnancy, Labor, Delivery and Neonatal Period***

Is child adopted? ◇ No ◇ Yes Date Of Adoption \_\_\_\_\_

Pregnancy: ◇ Uncomplicated ◇ Problems: \_\_\_\_\_  
\_\_\_\_\_

Labor/Delivery: ◇ Uncomplicated ◇ Problems: \_\_\_\_\_  
◇ C-Section \_\_\_\_\_

Full-term birth: ◇ Yes ◇ No, \_\_\_\_\_ Weeks Birthweight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

Post-delivery medical assistance [i.e., oxygen] ◇ No ◇ Yes, \_\_\_\_\_  
\_\_\_\_\_

Anything unusual about baby's condition at birth: ◇ No ◇ Yes, \_\_\_\_\_  
\_\_\_\_\_

Were there any early feeding problems: ◇ No ◇ Yes, \_\_\_\_\_  
\_\_\_\_\_

***Early Observations of Baby***

What attitude or mood did the baby seem to express most of the time? [For example, happy, smiling, laughing, "an easy baby", cuddly, inconsolable much of the time, crying, irritable, "difficult baby", etc.]

\_\_\_\_\_

Generally, babies vary with regard to the extent of activity they show. Which of the following do you think would most nearly describe your baby during the first few months of life?

- ◇ Showed a great deal of activity such as squirming, wiggly, kicking, or otherwise moving about so that it caused concern or difficulty.
- ◇ Showed very little physical activity, not even showing any increase in movement, interest or response when hungry or played with.
- ◇ Showed vigorous activity when awake and when played with but was equally often observed playing quietly and generally relaxed.
- ◇ Other \_\_\_\_\_

# Growth and Development

## *Motor Development*

Ages: \_\_\_\_\_  
                     Sat alone                      Crawled                      Stood alone                      Walked alone

Any rhythmic activity [rocking himself/herself, head banging, etc.]     No     Yes, \_\_\_\_\_

Generally active                       Generally quiet                       Excessively quiet                       Excessively crying

General Coordination:    Fine Motor Skills:                      Motor concerns in the past or currently (were OT or PT services obtained?):  
 Excellent                       Excellent                      \_\_\_\_\_  
 Good                       Good                      \_\_\_\_\_  
 Poor                       Poor                      \_\_\_\_\_

## *Speech/Language Development*

Ages:    Age of first words \_\_\_\_\_                      Age of first sentence \_\_\_\_\_

Stuttering:     No     Yes, at age \_\_\_\_\_                      Did speech begin and then stop:     No     Yes, at age \_\_\_\_\_

General development in this area:                      Speech/language concerns in the past or currently (was speech therapy obtained?):  
 Excellent                      \_\_\_\_\_  
 Good                      \_\_\_\_\_  
 Poor                      \_\_\_\_\_

## *Self-Help Development*

### ***Feeding:***

Feeding problems:                       Child seems overly messy                       Overeats                       Doesn't eat enough                       Selective ["picky"]

Family eats meals together:     Yes     No     Sometimes                      Mealtime is:     calm time     chaotic time

Other oral issues:                       Chews on shirt, sleeves, objects                       Food spills from mouth w/o notice                       Fingers often in mouth

Comments regarding self help: \_\_\_\_\_  
 \_\_\_\_\_

### ***Toileting:***

Ages: \_\_\_\_\_  
                     Toilet training started                      Bladder trained                      Bowel control achieved

Comments: \_\_\_\_\_

### ***Nutrition: Please note the frequency in which your child has the following:***

	Often	Sometimes	Rarely
Carbs			
Protein			
Veggies			
Fruit			
Chips/crackers			
Sweets			
Soft drinks / caffeine			
Multivitamin			

Are you generally satisfied with your child's nutrition?     Yes     No    Comments: \_\_\_\_\_



Child has frequent temper tantrums:  Yes  No When? \_\_\_\_\_

Method for handling tantrums in family: \_\_\_\_\_

Child strikes out at you and other family members:  Yes  No Plays too rough with pets:  Yes  No

Child is very sensitive:  Yes  No Feelings easily hurt:  Yes  No

Child:  cries a lot  seems sad  is moody  frequently mopes  needs much structure

gets overexcited easily  seems tense/anxious much of the time  not adaptable/flexible

Child's interpersonal/emotional strengths? \_\_\_\_\_

Child's interpersonal/emotional weaknesses? \_\_\_\_\_

Comments \_\_\_\_\_

### ***Play, Peers and Other Activities***

Child seems content with friendships:  Yes  No \_\_\_\_\_

Number of friends child has:  many  some  few  other \_\_\_\_\_

Friends' ages:  same-age or grade  older  younger Prefers:  older OR  younger children

Shares belongings easily:  Yes  No Prefers:  loud, active play OR  quiet play OR  Balance of both

Frequently plays alone:  No  Yes (Why?) \_\_\_\_\_ Can "stick up for" self:  Yes  No  Sometimes

Does child have difficulties with friendships/social interactions? If so, describe \_\_\_\_\_

Special talents, interests or hobbies: \_\_\_\_\_

Participates in Scouts, sports teams, or other organized activities or groups; which ones?  No  Yes, \_\_\_\_\_

Hours of "screen time" (TV, Xbox, etc.) per day: \_\_\_\_\_ weekdays \_\_\_\_\_ weekends

Specific "chores" at home:  No  Yes, include: \_\_\_\_\_

\_\_\_\_\_ Is child responsible in completing these duties:  Yes  No

Comments: \_\_\_\_\_

### ***Discipline***

Is discipline of child a problem--at home or at school? \_\_\_\_\_

Who handles most of the discipline in your home? \_\_\_\_\_

How is discipline most often handled? \_\_\_\_\_

**General Medical Health**

Child's health is:       Excellent       Good       Poor

Accidents:  No  Yes, \_\_\_\_\_  
Type Age(s)

Hospitalizations/Procedures: (e.g. ear infections, concussions, surgeries)

No  Yes, \_\_\_\_\_  
Reason Age(s)

If history of concussion, please explain details: \_\_\_\_\_

Illnesses other than usual childhood illnesses: \_\_\_\_\_

Child on medication:  No  Yes, \_\_\_\_\_  
Name of Medication Dosage

Reason for Medication Monitoring Physician

Child ever on Medication for attentional, emotional or other similar issues (Describe) \_\_\_\_\_

**Educational History**

COMPLETE NAME OF SCHOOLS ATTENDED	LOCATION (CITY)	Give Age for Preschool/ Give GRADE for School
PRESCHOOL		Ages
ELEMENTARY / SECONDARY		Grades

Child ever received tutoring:  No  Yes, \_\_\_\_\_  
Grade Level Subjects Tutor's Name

Does your child presently receive accommodations at school (e.g. extended time, re-explanation of directions)?

No  Yes, specify: \_\_\_\_\_

Child received special education services [Jump Start, Resource Room/remedial program]:

No  Yes, \_\_\_\_\_  
Grade Levels Subject(s)

Child has been RETAINED (Repeated a grade/year ) in preschool or in school:  No  Yes, \_\_\_\_\_ Grade

Child completed pre-primary (or K-1 or Transition) class between Kindergarten and first grade:  No  Yes

Was entrance into Kindergarten delayed?  No  Yes, decision made by  Parents  Other \_\_\_\_\_

Have school officials ever suggested/recommended retention in a grade but recommendation not accepted by your family?

No  Yes, \_\_\_\_\_ Grade

Have you been generally pleased with your child's teachers:  Yes  No

Strongest academic or developmental area: \_\_\_\_\_ Weakest academic or developmental area: \_\_\_\_\_ Subjects child enjoys most: \_\_\_\_\_

If school-aged, what do you *estimate* is child's reading level? \_\_\_\_\_ math level? \_\_\_\_\_

Did child have difficulty learning to read?  Yes  No Has child completed the SAT?  Yes  No

Please note any family history of learning difficulties, attentional, behavioral or other similar problems:

in Mother's Family

in Father's Family

_____	_____
_____	_____
_____	_____

Have you as parent(s) or the child's school(s) noticed/suspected any problems with the following:

	Parent(s)	School(s)		Parent(s)	School(s)
Attention span	<input type="checkbox"/>	<input type="checkbox"/>	Personality "conflict" with teacher	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	Poor organization	<input type="checkbox"/>	<input type="checkbox"/>
Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	Loses school work	<input type="checkbox"/>	<input type="checkbox"/>
Activity level	<input type="checkbox"/>	<input type="checkbox"/>	Can't remember assignments	<input type="checkbox"/>	<input type="checkbox"/>
Fidgetiness	<input type="checkbox"/>	<input type="checkbox"/>	Forgets to bring work home	<input type="checkbox"/>	<input type="checkbox"/>
Frustration for school work	<input type="checkbox"/>	<input type="checkbox"/>	Getting started on work	<input type="checkbox"/>	<input type="checkbox"/>
Explosiveness	<input type="checkbox"/>	<input type="checkbox"/>	Completing work	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	Remembering to turn in work	<input type="checkbox"/>	<input type="checkbox"/>
Worried about schoolwork/tests	<input type="checkbox"/>	<input type="checkbox"/>	Won't do homework	<input type="checkbox"/>	<input type="checkbox"/>
Takes a long time to do work	<input type="checkbox"/>	<input type="checkbox"/>	Can't work independently	<input type="checkbox"/>	<input type="checkbox"/>

Does the child have a designated space for homework that is effective? \_\_\_\_\_ Yes \_\_\_\_\_ No

Average daily time spent on homework: \_\_\_\_\_

Does amount of time spent on homework seem: \_\_\_\_\_ Too Long \_\_\_\_\_ Appropriate \_\_\_\_\_ Too Little

Other: \_\_\_\_\_

**ATTENTION, IMPULSIVITY, AND ACTIVITY PROBLEMS**

DIRECTIONS: For each item, place an "X" in the category that applies to your child, *compared to most children of the same age*. **Please note the age range the behavior was observed** (e.g. always, 3-5 yrs, 10-15 yrs)

**Severe:** Occurs frequently, daily; **Moderate:** Occurs fairly often; **Mild/Not a Problem:** Occurs rarely **Age:** when symptoms seen

		Severe	Moderate	Mild/ Not Present	Age Range of Symptom
1	Is forgetful of daily activities				
2	Makes careless errors or fails to give close attention to details				
3	Avoids or dislikes engaging in tasks that require sustained mental effort				
4	Gets distracted easily by extraneous stimuli				
5	Does not follow through on instructions or tasks (e.g. chores, homework)				
6	Difficulty sustaining attention in tasks or play activities				
7	Often doesn't seem to hear what you say				
8	Often loses items necessary to tasks or activities [e.g., toys, books, pencils]				
9	Stares or listens to outside noises for long periods				
10	Confused, seems to be in fog				
11	Has difficulty awaiting turn in games or group situations				
12	Often blurts out answers to questions before they have been completed				
13	Often interrupts or intrudes [e.g., butts into other's games]				
14	Acts without thinking, does things on impulse				
15	Doesn't learn from experience				
16	Seems to do things the hard way; has difficulty organizing work				
17	Needs a lot of supervision (more than expected for child's age)				
18	Often fidgets with hands or feet or squirms in seat				
19	Has difficulty remaining seated [e.g., meals, storytime]				
20	Often shifts from one uncompleted activity to another				
21	Has difficulty playing quietly				
22	Often talks excessively				
23	Mind seems overactive				
24	Body is in constant motion; always on the go				
25	Has an excessive number of accidents				
26	Breaks things around the home				
27	Is hard to control on long car trips				
28	Can't keep hands to himself/herself				
29	Moves about excessively during sleep				
30	Body is underactive				

At some time during their lives, most children show some of the symptoms listed below. For each item, please check the column that best describes your child, *compared to peers*. Please include symptoms that, while no longer present, were a problem in the past. FOR EACH SYMPTOM PRESENT - NOW OR IN THE PAST - give the ages when the problem occurred and indicate any pertinent information near the item or in the space at the end of the checklist.

**Severe:** Occurs frequently, daily; **Moderate:** Occurs fairly often; **Mild/Not a Problem:** Occurs rarely **Age:** when symptoms seen

	SYMPTOM	SEV	MOD	NOT	AGE
<b>DISRUPTIVE BEHAVIOR</b>					
1	Often loses temper				
2	Often argues with adults				
3	Openly disobeys authority				
4	Deliberately does things that annoy others				
5	Often blames others for own mistakes				
6	Irritable or easily annoyed by others				
7	Often angry and resentful				
8	Often spiteful or vindictive				
9	Often swears or uses obscene language				
10	Very stubborn				
11	Negativistic [does the opposite of what is asked]				
12	Quietly defies authority even if pretends or verbalizes cooperation				
13	Dawdles, procrastinates				
14	Steals				
15	Runs away from home				
16	Often lies				
17	Sets fires				
18	Often truant from school				
19	Has broken into a house, building or car				
20	Deliberately destroyed others' property				
21	Physically cruel to animals				
22	Forced someone into sexual activity with him/her				
23	Used a weapon				
24	Often initiates physical fights				
25	Has stolen w/ confrontation of victim [e.g.,mugging]				
26	Physically cruel to people				
27	Gets in trouble with neighbors				
28	Gets in trouble with police				
29	Abuses drugs or alcohol				
30	Has little guilt over behavior that hurts others				
31	Does not respond to punishment for anti-social behavior				

	SYMPTOM	SEV	MOD	NOT	AGE
<b>IMMATURE BEHAVIOR</b>					
32	Thumb-sucking or finger sucking				
33	Uses baby talk				
34	Has an imaginary companion				
35	Low frustration tolerance				
36	Excessive demands [for attention, objects, etc.]				
37	Cries, pouts, whines, or sulks easily and frequently (circle ones that apply)				
38	Frequently tries to avoid responsibility				
39	Generally immature (acts younger than age) or too dependent on others				
<b>FEARS AND WORRIES</b>					
40	Worry that something bad will happen to parents				
41	Fear that parents will leave and not return				
42	Worry that something bad will happen to him/her [e.g., kidnapping]				
43	Reluctance or refusal to attend school, often ill on school days				
44	Fear of sleeping alone				
45	Fear of sleeping away from home				
46	Fear of being alone, stays close to parents				
47	Excessive distress in anticipation of separation from parents				
48	Excessive distress while separated from parents				
49	Fear of going away to camp				
50	Excessive worry about future events				
51	Excessive worry about the appropriateness of past behavior				
52	Excessive worry about abilities [e.g. athletic, academic], is perfectionistic				
53	Frequent complaints of aches and pains				
54	Easily embarrassed, or seems very self-conscious				
55	Excessive need for reassurance				
56	Excessive worries and tension, seems unable to relax				
57	Anxiety attacks with heart pounding, shortness of breath, sweating, etc.				
58	Fears of heights, open or closed spaces, elevators, or other concerns (circle)				
59	Fear of new situations or strangers				
60	Fear of animals				
61	Fear of death				
62	Fear of dark				
63	Specify other fears:				

	SYMPTOM	SEV	MOD	NOT	AGE
<b>PEER RELATIONS</b>					
64	Plays alone too much (when playmates are available)				
65	Has few, if any, real friends				
66	Has mostly friends of the opposite sex				
67	Has mostly younger friends (children NOT in same grade)				
68	Has mostly older friends (children NOT in same grade)				
69	Does not seek friendships				
70	Is rarely sought by peers				
71	Is slow to make friends				
72	Loses friend easily				
73	Is not liked by other children				
74	Gets picked on, or bossed, by other children				
75	Often bullies, hits, or teases other children				
76	Insists on having his/her own way with peers				
77	Is not aware of the needs and feelings of others				
78	Braggs or boasts excessively				
79	Is excessively competitive				
80	Often cheats while playing games				
81	Is a "sore loser"				
82	Is gullible, easily led				
<b>SOCIAL RELATIONS</b>					
83	Shows poor common sense in social situations				
84	Often feels cheated or picked on				
85	Suspicious, distrustful				
86	Shy or withdrawn				
87	Backs off from affectionate physical contact				
88	Fears asserting self				
89	Inhibits open expression of anger				
90	Excessive desire to please authority, is "too good"				
91	Often appears insincere, artificial				
92	Frequently acts older than actual age				
93	Frequently blames others for own shortcomings				
94	Gets along poorly with brothers and sisters				
95	Has low self-esteem, does not respect self				
96	Lacks confidence, feels inadequate, criticizes self				
97	Asks to be punished				
98	Dissatisfied with physical appearance				
99	Excessively modest regarding bodily exposure				

	SYMPTOM	SEV	MOD	NOT	AGE
100	Has little regard for personal appearance or hygiene				
101	Has little regard for, or pride in, personal property				
<b>MISCELLANEOUS PROBLEMS</b>					
102	Eats things that are not food				
103	Picky eater				
104	Passes feces into inappropriate places [e.g. pants or floor]				
105	Wets bed or pants often				
106	Trouble falling or staying asleep (circle which ones)				
107	Frequent nightmares or night terrors [panics]				
108	Sleep walking or sleep talking (circle which ones)				
109	Is often tired				
110	Excessive sexual interest and preoccupation				
111	Excessive masturbation				
112	Often wishes to be the opposite sex				
113	Frequently likes to wear clothing or exhibit gestures of the opposite sex				
114	Bites fingernails or chews on objects				
115	Pulls hair or picks at nose, skin, etc.				
116	Bangs head or rocks body				
117	Nervous movements or twitches [e.g., eye blinking; facial grimacing; neck twitching]				
118	Involuntary grunts or vocalizations				
119	Stutters, stammers, or speaks rapidly with poor phrasing (circle which ones)				
120	Persistently refuses to talk in certain situations [e.g. school; with strangers]				
121	Usually sad				
122	Often feels hopeless				
123	Does not respond with pleasure to praise				
124	Talks about or attempts suicide				
125	Fantasizes excessively ["lives in own world"]				
126	Shows little emotion [flat emotional tone]				
127	Hears things that are not there				
128	Sees things that are not there				
129	Repeats certain acts over and over				
130	"Gets hooked" on certain ideas or topics of conversation				
ADDITIONAL INFORMATION REGARDING SPECIFIC ITEMS ABOVE					

Please describe your child's strengths and talents. What do you like most about your child? What do others like about your child?

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What other information would be useful for Dr. Hill to know about your child before conducting the scheduled evaluation?

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This questionnaire completed by:

Signature \_\_\_\_\_

Circle:    Mother      Father      Both Parents

Date: \_\_\_\_\_

**RETURN WITH SIGNATURE FORMS AT THE TIME OF TESTING**