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Parent Questionnaire and Developmental History

Instructions: Please complete this questionnaire prior to your first appointment. At your initial appointment, you will review this information together with your service provider so that you have the opportunity to expand your responses and/or provide clarification. Completing this in advance of your first appointment should help you to organize your thoughts regarding the reasons you are seeking an evaluation and/or treatment. Thank you!

Form completed by:_____

Relationship to child:_____ Date:_____

Reason for referral

Child was referred for assessment by: _____

Please briefly describe the reason for referral and your goal in seeking an evaluation:

_____

_____

_____

_____

Demographic Information

Child's Full Name:_____ Preferred Name:_____

Date of Birth:_____ Age:_____ Sex: M/F

Child's race/ethnicity:_____

Was the child born in the United States? Y/N _____

Child's primary language:_____ Secondary:_____

Are any languages other than the child's primary language spoken in the home? Y/N

If yes, please list all languages: _____

Right/Left Handed:_____

School of attendance: _____ Current grade: _____

Family History

Father's Name: _____ Occupation: _____

Highest Level of Education: _____ Currently employed? Y/N

Mother's Name: _____ Occupation: _____

Highest Level of Education: _____ Currently employed? Y/N

Child lives with (indicate relationship and age of each individual):

_____

_____

_____

Was your child adopted: Y/N If yes, at what age and what were the circumstances surrounding the adoption?

_____

_____

Child's parents/legal guardians are: married _____ divorced _____ separated _____ never married, but live together _____ never married and live apart _____

parent(s) deceased _____ other _____

If parents are divorced, please indicate custody arrangements:

_____

If parents are divorced, does the individual seeking this evaluation have medical decision making authority? Yes_____ No_____

Has the child had any other significant caregivers (i.e., persons who cared for the child for extended periods of time or with great frequency)? Y/N If yes, please explain:

_____

_____

Is there any history of learning problems among your child's immediate or extended family members? Y/N If yes, please explain:

_____

_____

Please note any known family history of mental illness:

_____

_____

Developmental History

(If your child was adopted, please provide any information known)

Was pregnancy full term? Y/N If no, please note gestational age at birth and provide any known information regarding the causes of premature delivery: -

_____

_____

Please identify any complications during pregnancy:

_____

_____

Was your child born by vaginal delivery or cesarean? _____

Birth Weight: _____

Was child healthy at birth? Y/N If no, please explain:

_____

_____

Please identify any birth complications:

_____

_____

Did the child have any exposure to medications (prescription or otherwise), drugs, tobacco products, or alcohol during pregnancy? Y/N If yes, please explain:

_____

_____

As an infant did your child have difficulty with any of the following:

_____ Feeding _____Weight Gain _____Sleeping

Please explain:_____

Please briefly describe your child's temperament as an infant:

_____

Please identify the age at which your child met the following milestones:

_____ sat unassisted _____crawled _____walked

_____spoke first words _____used 2-3 word sentences

_____spoke in full sentences

Did any pediatrician or other early childhood professional voice concern about meeting developmental milestones, fine or gross motor development, language skills, social skills, or self-help skills? Y/N If yes, please explain:

_____

_____

Have you, or others, ever observed your child to have difficulty with the development of social skills such as maintaining appropriate eye contact, playing appropriately with other children, demonstrating awareness of give-and-take in conversations and social relationships, engaging appropriately with both known and unknown people? Y/N If yes, please explain:

_____

_____

Was your child's play typical for children his/her age? For example, as a preschooler, did he/she engage in imaginary play? Did he/she become preoccupied with one type of play, toy, or interest to the exclusion of other activities? Please list any concerns in this area:

_____

_____

As a young child, and/or currently, did your child display extreme sensitivities to any of the senses (light, sounds, touch, smells, tastes)? If so, please describe:

_____

_____

Please note any additional concerns about development:

_____

_____

Medical History

Child's pediatrician or primary care physician:_________

Does Rocky Mountain Center for Development have your permission to contact your child's physician to gather information about relevant medical history and/or to share the outcome of this assessment? Yes_____ No_____

Please list any current medical diagnoses or concerns:

_____

_____

_____

Please list any medications (prescription or otherwise) being used at this time:

_____

_____

_____

Has your child ever taken psychiatric medications? Yes_____ No_____ If yes, please explain:

_____

_____

Please list any significant medical issues including surgeries, hospitalizations, head injuries, loss of consciousness, seizures, broken bones, chronic illnesses (including ear infections), high fevers, and significant accidents:

_____

_____

_____

_____

Has your child ever had a hearing test: Y/N Date/Result: _____

Has your child ever had a vision test: Y/N Date/Result: _____

Please describe any concerns regarding your child's sleep patterns or eating habits (e.g., doesn't sleep through the night, doesn't stay in own bed, nightmares, bed wetting, over-eats, under-eats, extreme food preferences):

_____

_____

_____

How frequently does your child drink beverages with caffeine? _____

Do you have any concern about or suspicion that your child is using illicit drugs, alcohol, or tobacco products? Y/N If yes, please explain:

_____

_____

Educational History

Please identify your child's primary teacher or school representative most familiar with child's functioning: _____

Does Rocky Mountain Center for Development have your permission to contact this individual and/or other representatives of your child's school as a means of gathering information about your child's functioning in the academic setting? Yes _____ No_____

Did your child attend preschool? Y/N

If yes, where?_____ How many years/months? _____

Were there concerns regarding your child's behavior, social skills, or pre-academic skills in preschool? Y/N

If yes, please describe concerns:

_____

_____

_____

Please list the schools (and dates) your child has attended since preschool:

School	Dates	Grades

If there is a history of frequent changes in school placement, please explain:

_____

_____

_____

Are there currently concerns related to your child's functioning in his/her academic environment? Y/N If yes, please explain:

_____

_____

When did concerns related to functioning in the school environment first arise?

_____

In reflecting on your child's education, are there now or have there ever been concerns related to any of the following skills (check all that apply):

Ability to rhyme_____ Learning letters_____ Learning letter sounds_____

Reading words_____ Reading Fluency_____ Reading Comprehension_____

Learning numbers_____ Math skills_____ Recalling Math Facts_____

Retention of information_____ Mastery of new concepts_____

If you checked any items above, please explain:

_____

_____

_____

In reflecting on your child's education, are there now or have there ever been concerns related to any of the following (check all that apply):

Attention_____ Distractibility_____ Organizational skills_____

Work completion_____ Quality of work_____ Effort_____

Careless errors_____ Forgetfulness_____ Procrastination_____

Self-control_____ Restlessness_____ Calling out in class_____

Ability to independently manage tasks and/or materials_____

If you checked any items above, please explain:

_____

_____

_____

Are there concerns regarding your child's social functioning at school? Y/N If yes, please explain:

_____

_____

List child's favorite school/academic activities or subjects:

_____

_____

Least favorite academic activities/subjects:

_____

_____

What are your child's strengths in an academic setting:

_____

_____

What are your child's weaknesses in an academic setting:

_____

_____

Average time spent on homework: _____ Is this a struggle?_____ If yes, please describe:

_____

_____

Does your child read independently? Y/N

Does your child enjoy reading or being read to? Y/N

History of Interventions and Services

Has your child been evaluated in the past due to developmental, academic, or psychological concerns? Y/N

If yes, list names of evaluators, dates of evaluation, reason for evaluation, and brief results (please bring copies of reports if possible):

_____

_____

_____

_____

Is your child currently, or has he/she ever in the past, worked with a psychiatrist, psychologist, psychotherapist, or other mental health professional? Please list provider names and dates of treatment:

_____

_____

_____

_____

Is your child currently, or has he/she ever in the past, received therapies such as speech, OT, PT, vision therapy OR educational interventions/supports including tutoring and/or academic coaching? Please list provider names, types of services, and dates of involvement:

_____

_____

_____

_____

Has your child ever received pull out services at school, repeated or skipped a grade level, had a behavior plan or been placed on an ILP, IEP, 504 or accommodation program? Y/N If yes, please explain (and provide any available documents):

_____

_____

Has your child previously been diagnosed with AD/HD or a learning disability (e.g.,dyslexia), or any other learning related problem? Y/N

If yes, please explain:

_____

_____

Social/Emotional functioning

Do you have any concerns about your child's current mood, emotional stability, or mental health? Y/N If yes, please explain:

_____

_____

Have you ever had concerns related to your child's safety including extreme risk-taking behaviors, self-injurious behaviors, or suicidal ideations? Yes_____ No_____
If yes, please explain:

_____

_____

In thinking about your child's mental health, do you have concerns related to any of the following:

Excessive worry_____ Difficulty controlling/managing worry_____
Changes in sleep patterns_____ Easily fatigued/loss of energy_____
Weight loss/gain_____ Changes in appetite_____
Loss of interest in activities_____ Irritability_____
Persistent feelings of sadness_____ Difficulty making decisions_____
Feelings of hopelessness/guilt_____

Are you concerned about your child's relationships or lack of relationships with friends? Y/N If yes, please explain:

_____

_____

What are your child's interests?

_____

_____

What does your child enjoy doing outside of school?

_____

_____

Does your child get bullied (or bully others)? Y/N If yes, explain:

_____

_____

Any other concerns not addressed on this form?

_____

_____

Signature of individual completing this questionnaire:

_____ Date:_____

Thank you!