# Johnson Neuropsychology, PLLC
## Parent Questionnaire

Please answer the following questions carefully and completely. Your answers will help us greatly in our understanding of your child. The questionnaire will be reviewed with you, so it will be possible to discuss your answers if you wish.

CHILD'S NAME:_____ DATE:_____
NICKNAME:_____ AGE:_____ DATE OF BIRTH:_____
GENDER: Male Female ETHNICITY: _____
HANDEDNESS (If established): Right Left
NAME OF LEGAL GUARDIANS: _____
PERSON COMPLETING FORM:_____ RELATION TO CHILD:_____
HOW WERE YOU REFERRED? _____

**PROBLEMS AND CONCERNS**

Please list, in order of urgency, the problem(s) for which you are seeking help for your child:

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

**FAMILY HISTORY**

**1. Who is this child currently living with? (check all that apply)**

☐both natural parents ☐stepmother ☐adoptive parents

☐natural mother ☐stepfather ☐grandparent *circle:* grandmother, grandfather / mother's side, father's side

☐natural father ☐foster parents ☐other (describe)_____

**2. Parental information**

| | **Mother** | **Father** |
|---|---|---|
| Occupation: | | |
| Age: | | |
| Highest grade completed: | | |

**3. . List all people living in the child's home?**

Name Age Relation to child

**4. What languages are spoken in the home? What languages does your child speak, and how proficient are they? What was your child's first language?**

**5. Please describe the current marital status/custody information.**

**6. Please list the important events or changes that have occurred in your child's lifetime (for example: deaths, marital separations, divorces, remarriages, family moves, loss of important friendships, serious illnesses, financial problems, parental conflict, family violence, etc.). List any other events which, in your opinion, have had important meaning or significant impact on your child or your family. If you are uncertain about the significance, please list it anyway. Please provide specific dates during which each event occurred and identify the persons involved.**

Dates or ages Changes

## PREGNANCY

**1. Was the pregnancy *(check all that apply):*** ☐planned ☐unplanned ☐wanted ☐unwanted ☐with prenatal care ☐without prenatal care

**2. Age of parents at time of child's birth:** _____mother _____father

**3. While mother was pregnant, did she have any of the following difficulties?**

Chronic Disease: Yes No

Accidents/Injuries: Yes No

Surgeries: Yes No

Medications: Yes No

Alcohol Intake: Yes No

Drug Use: Yes No

Smoke Cigarettes: Yes No

Exposure To Toxic Chemicals Or Substances: Yes No

Stressful Events For One Or Both Parents: Yes No

## DELIVERY

**1. How long did labor last:_____2. Baby's weight at birth: _____**

**3. Was baby full term? _____If not, how many weeks premature?_____**

**4. Length of hospital stay for mother? _____Length of stay for child?_____**

**5. Were any of the following present during or soon after delivery? *(check all that apply)***

- ☐mother was put to sleep
- ☐C Section performed
- ☐Instruments used to deliver
- ☐Rh factor present
- ☐breech birth or presentation
- ☐born with cord around neck
- ☐baby was blue
- ☐baby was jaundiced (yellow)
- ☐baby aspirated meconium (breathed waste)
- ☐baby needed blood
- ☐baby needed oxygen
- ☐baby had trouble sucking
- ☐baby had trouble keeping food down
- ☐baby was placed in an incubator. For how long?_____
- ☐other medical problems at birth (describe): _____

**DEVELOPMENTAL HISTORY:**

**1. Did any of the following occur during infancy**? ***(check all that apply)***

- ☐baby had problems sleeping_____
- ☐baby was frequently fussy or colicky _____
- ☐baby had unusual crying_____
- ☐baby had trouble breathing_____
- ☐baby had problems eating or gaining weight_____
- ☐baby experienced convulsions, seizures, or "staring spells"_____
- ☐baby had excessive diarrhea or dehydration _____
- ☐mother was depressed, anxious, or unusually stressed _____
- ☐mother was physically ill or injured _____

**2. Who was primarily responsible of baby's caretaking**? _____

Who assisted in the baby's care? _____

**3. During your child's first year of life, was there anything (even if it had nothing to do with the baby) that caused unhappiness in the family, or placed the mother or father under special strain?**

_____

_____

_____

_____

**4. Did mother (or primary caretaker) work before this child entered daycare/school? ____**yes ____no

If yes, who cared for this child while the mother worked?

☐babysitter ☐family member: _____ ☐day care center(s)

**5. How do you feel your child is developing in the following areas?**

| | | | |
|---|---|---|---|
| Physical & Motor Development | ☐faster than average | ☐average | ☐slower than average |
| Talking & Language Development | ☐faster than average | ☐average | ☐slower than average |
| Relationships and Social Development | ☐faster than average | ☐average | ☐slower than average |

| Developmental Skill | Approximate Age |
|---|---|
| Crawled | |
| Walked | |
| Spoke first words | |
| Spoke simple phrases | |
| Spoke in sentences | |
| Followed simple instructions | |
| Toilet trained, day | |
| Toilet trained, night | |

**6. Does your child have any problems in the following areas?:**

| | | | | | |
|---|---|---|---|---|---|
| Learning the names of colors and shapes | □ No | □ Yes | Cutting with scissors | □ No | □ |
| Learning to riding a 2-wheeled bicycle | □ No | □ Yes | Learning to tell time | □ No | □ |
| Learning to climb stairs, hop, or skip | □ No | □ Yes | Learning to tie shoes | □ No | □ |
| Learning to use zippers or buttons | □ No | □ Yes | Separating from parents | □ No | □ |
| Giving appropriate eye contact | □ No | □ Yes | Making friends | □ No | □ |
| Learning the names or sounds of letters | □ No | □ Yes | Learning to read | □ No | □ |
| Learning how to write letters or numbers | □ No | □ Yes | Learning to count or add | □ No | □ |
| Learning right and left | □ No | □ Yes | Reciting the alphabet | □ No | □ |
| Understanding jokes | □ No | □ Yes | Adjusting to change | □ No | □ |

**7. Describe anything else hard for him/her to learn or master:** _____

_____

_____

**8. Did family, friends, etc. ever have difficulty understanding his/her speech?** □ No □ Yes:

**MEDICAL HISTORY**

**1. Please give details of any medical problems, procedures, surgeries, or prior hospitalizations for your child (Use back of sheet if necessary).**

Type Age

_____

_____

_____

_____

_____

**2. Please write the ages (in years) that your child had any of the following illnesses:**

| Ages | Ages | Ages |
|---|---|---|
| _____Allergies | _____Frequent Ear Infections | _____Oxygen Deprivation |
| _____Asthma | _____Frequent Stomachaches | or Near drowning |
| _____Blood Transfusion | _____Head Injuries/Concussion | _____Pneumonia |
| _____Convulsions/ Seizures | _____Headaches | _____Prolonged Colic |
| _____Diabetes | _____Heart Trouble | _____Tonsillitis |
| _____Fainting | _____High Fever | _____Tics, Twitching |
| _____Frequent Colds/Sore Throats | _____Infections (Meningitis, Encephalitis) | |
| _____Frequent Ear Aches | _____Major Factures | Other:_____ |

**3. My child's present medications and/or supplements are:**

| Medication | Dosage | Frequency | Helpful? | Side Effects? |
|---|---|---|---|---|
| | | | Y/N/DK | |
| | | | Y/N/DK | |
| | | | Y/N/DK | |
| | | | Y/N/DK | |
| | | | Y/N/DK | |
| | | | Y/N/DK | |
| | | | Y/N/DK | |
| | | | Y/N/DK | |

**Allergies/drug intolerances (describe):**_____

**Ever been tested for food allergies? Yes/No *Describe***_____

**4. Vision and hearing:**
Vision (circle): Normal Corrected Needs to be checked
Hearing (circle): Normal Corrected Needs to be checked

**5. Please describe your child's eating habits. Note any problems in this area.**

_____

_____

**6. Please describe your child's sleeping habits. (circle all that apply):**
sleepwalking nightmares recurrent dreams sleeps with light on difficulty falling asleep
wakes up during the night difficulty getting up must sleep with another person

Does your child's legs jump often or does he/she kick the blankets off at night? Yes/No
Does your child snore? Yes/ No If yes: a. Is your child overweight? Yes/No
Does your child have periods that he/she stops breathing while sleeping Yes/No

**7. Any Family History (immediate & extended [close relatives]) of:**

| | YES | NO | Which Family Member(s)? |
|---|---|---|---|
| Learning Problems | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ |
| ADD / ADHD | _____ | _____ | _____ |
| Hyperactivity | _____ | _____ | _____ |
| Problems paying attention | _____ | _____ | _____ |
| Dyslexia | _____ | _____ | _____ |
| Mental Retardation | _____ | _____ | _____ |
| Speech/Language Disorders | _____ | _____ | _____ |
| Autism / Asperger's / PDD | _____ | _____ | _____ |
| Seizures | _____ | _____ | _____ |
| Emotional problems | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ |
| Extreme nervousness | _____ | _____ | _____ |
| Explosive temper | _____ | _____ | _____ |
| Convulsions or seizures | _____ | _____ | _____ |
| Extreme shyness | _____ | _____ | _____ |
| Drinking problem/alcoholism | _____ | _____ | _____ |
| Drug problem/addiction | _____ | _____ | _____ |
| Sexual abuser | _____ | _____ | _____ |
| Victim of sexual abuse | _____ | _____ | _____ |
| Sleep problems | _____ | _____ | _____ |
| Bipolar Disorder (manic depression) | _____ | _____ | _____ |
| Anxiety | _____ | _____ | _____ |
| Left-handedness or mixed-handedness | _____ | _____ | _____ |

Other (Please Explain):

_____

_____

_____

## SCHOOL HISTORY

**1. School/Daycare Name:_____**
**2. Did/Does your child attend day care? Yes No__How old was your child when s/he started?_____**
If yes, describe the setting and the child's reaction to it? _____

_____

**3. Has your child received or is currently receiving Early Intervention Services (e.g. Head Start or PPCD)?**
**_____Yes _____No**
If yes, age at start of services? _____How often? _____When did services end?_____
Services received: (Circle all that apply): Speech/Language Physical Therapy Occupational Therapy
Other: _____

**4. Are there any BEHAVIOR PROBLEMS in school? Yes No**
**Has your child every been asked to leave a daycare? Yes No**

_____
_____
_____
_____

**5. (For ages 3+) Does your child have an Individualized Education Program (IEP)? Yes No**

Please indicate if your child may have received any of the following services in ***school***.
_____Speech Therapy _____Physical Therapy _____Occupational Therapy
_____ABA _____Integrated Preschool _____Special Education

Special Education Qualification?: ***(mark all that apply)***
□ ID □ LD □ OHI □ TBI □ VI □ SI □OI □ED

**6. Has your child ever had any of the following *private* services?**
_____Speech Therapy _____Physical Therapy _____Occupational Therapy
_____ABA _____Other

**DISCIPLINE**

**1. Would you describe this child as obedient, or compliant with requests? _____**

**2. This child is disciplined by *(check all that apply):***

□mother □father □brother/sister □other:_____

**3. Discipline most often used (in order of frequency):_____**

_____

**4. Discipline that is most effective with this child: _____**

**5. Describe how this child reacts to punishment**:_____

**SOCIAL AND EMOTIONAL FUNCTIONING**

1. Describe this child's friendships: A leader or follower? Older or younger friends?

_____

2. Any problems in friendships (teasing, aggressiveness, rejection, etc.)? _____

3. How does this child show affection?_____

4. Is it hard for this child to trust other people?_____Does he/she feel comfortable around others?_____

5. Compared to other children of your child's age, how well does your child…

| | Worse | Same | Better | Comments |
|---|---|---|---|---|
| Get along with brothers/sisters | | | | |
| Get along with other children | | | | |
| Play/work by self | | | | |
| Behave in public (restaurants, etc.) | | | | |
| Behave with baby-sitters | | | | |
| Behave at daycare/school | | | | |

6. How often per week does this child have tantrums? What causes them? What does he/she do?

_____

_____

7. Is this child a worrier?_____ What types of types of things does he/she worry about? _____

_____

8. Describe any nervous habits (nail biting, thumb sucking, hair pulling, etc.) _____

_____

9. Describe any unusual or problem behaviors not described above: _____

_____

_____

_____

_____

**ACTIVITIES OF DAILY LIVING:**

How does the child like to spend his/her time?_____

What kinds of things does this child enjoy? _____

_____

_____

List current extracurricular activities: _____

_____

Please feel free to add additional comments.