Johnson Neuropsychology, PLLC
Parent Questionnaire 4-17 yrs

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(Circle one): Male Female PROUNOUNS:_____ETHNICITY: _____
HANDEDNESS (CIRCLE ONE): RIGHT LEFT AMBIDEXTROUS
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 (Use back of sheet if necessary):

A. _____

B. _____

C. _____

D. _____

E. _____

CHILD'S STRENGTHS: _____

_____

_____

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 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 developed 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. Did your child have any problems in the following areas?

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

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	_____	Menstrual Problems
_____	Asthma	_____	Frequent Stomachaches	_____	Oxygen Deprivation
_____	Blood Transfusion	_____	Head Injuries/Concussion		or Near drowning
_____	Convulsions/ Seizures	_____	Headaches	_____	Pneumonia
_____	Diabetes	_____	Heart Trouble	_____	Prolonged Colic
_____	Fainting	_____	High Fever	_____	Tonsillitis
_____	Frequent Colds/Sore Throats	_____	Infections (Meningitis, Encephalitis)	_____	Tics, Twitching
_____	Frequent Ear Aches	_____	Major Factures	Other:	

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

Medication	Dosage	Frequency	Helpful?	Date Started	Side Effects?
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		

4. Has your child ever taken medication for ADHD that resulted in no improvement or worse behavior? Describe:

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

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

_____

_____

7. 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

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

	YES	NO	Which Family Member(s)?
Learning Problems			
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			
Victim of abuse			
Sexual abuser			
Victim of sexual abuse Sleep			
problems			
Bipolar Disorder (manic			
depression) Anxiety			
Left-handedness or mixed-			
handedness			
Other (Please Explain):			

_____

_____

9. Has your child ever received counseling or testing for mental health or learning problems? Yes or No

_____

_____

_____

_____

_____

SCHOOL HISTORY

1. Current grade:_____ Current school:_____

2. Did 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 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. Has your child ever repeated a grade? Yes No If yes, what grade and what was the reason?

_____

5. *Is your child currently undergoing or in the process of receiving an initial evaluation or re-evaluation for special education?* Yes No

If yes, please reach out to the office directly for more information.

6. Does your child have or have they every had an Individualized Education Program (IEP)? Yes No

If yes, please attach a copy of your child's IEP and most recent school testing (Full Individual Evaluation).

At what age/grade did they first get an IEP? _____

Was it ever discontinued? Yes No

If yes, when and why? _____

Are you happy with the services your child receives? Yes No

Please indicate if your child may have received any of the following services in ***school***.

_____Speech Therapy _____Physical Therapy _____Occupational Therapy

_____Resource Room _____Content Mastery _____Special Education

Special Education Qualification: ***(mark all that apply)***

□ MR □ LD □ OHI □ TBI □ VI □ SI □OI □ED

7. Does your child have a 504 Accommodation Plan? Yes No

If yes, please attach a copy of your child's current plan and any school testing.

8. Does your child receive any informal support, accommodations, or help at school? Yes No

_____

_____

_____

_____

9. Please rate your child's current school performance (for children ages 6 and older):

Subject	Failing	Below Average	Average	Above Average
Reading or English				
Writing				
Math				
Spelling				
Sciences				
Other:				

10. Are there any BEHAVIOR PROBLEMS in school? Yes No
Suspensions or expulsions? Yes No

_____
_____
_____
_____

11. School homework for this child: ***(check all that apply)***

□ Is something s/he enjoys doing._____
□ Is a source of unhappiness and trouble._____
□ Is something s/he has to be forced to do._____

12. Your child usually studies:
Where? _____
When? _____
How long? _____

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:_____

6. Has your child ever been arrested? Yes No_____

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 feel really angry? What makes him/her feel that way? 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. 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				

10. How often per week does this child feel really angry? What makes him/her feel that way? What does he/she do?

_____

_____

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

_____

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

_____

13. 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 describe electronic/TV use at home:_____

_____

_____

What household chores is he/she responsible for? _____

How does he/she complete them? ***Check all that apply*** □Independently □With One Reminder

□With Several Reminders □With Assistance □Only After Being Disciplined Or Threatened With Discipline

ALCOHOL AND/OR DRUG USE: *It is important that the minor help complete this section completely and honestly.*

HAS THE MINOR EVER USED…	(Circle one)	Age minor began using	Is the minor currently using?	When did the minor last use?	How much does the minor use (or did use in the past)?
Alcohol (beer, wine, mixed drinks)……	Yes No		Yes No		
Marijuana……	Yes No		Yes No		
Amphetamines, Meth.: ☐ oral, ☐ nasal, ☐ IV, ☐ smoke……	Yes No		Yes No		
Cocaine: ☐ nasal or ☐ IV……	Yes No		Yes No		
Prescription medication in an abusive manner……	Yes No		Yes No		
Heroin…… ……	Yes No		Yes No		
Opiates (morphine, codeine, Demerol)……...	Yes No		Yes No		
Hallucinogens, PCP……	Yes No		Yes No		
Inhalants (glue, gas, spray)……	Yes No		Yes No		
Nicotine……	Yes No		Yes No		
Other:	Yes No		Yes No		

Previous Alcohol or Substance Abuse Treatment History:

Where	Year	Type Inpatient or Outpatient	Days/Months in treatment	Completed Program?	How long has the minor been sober/clean? (If applicable)
				Y N	
				Y N	

Please feel free to add additional comments:

Amen Child/Teen Brain System Checklist

Please rate your child/teen on each of the symptoms listed below using the following scale. If practical and/or possible, to give us the most complete picture, have your child rate him/herself first in the first column (CH/TN) Please list who completed this form._____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

CH/TN	Parent		
____	___	1.	Failing to give close attention to details or making careless mistakes
____	___	2.	Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
____	___	3.	Having trouble listening
____	___	4.	Failing to finish things
____	___	5.	Having poor organization for time or space (such as a backpack, room, desk, paperwork)
____	___	6.	Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
____	___	7.	Losing things
____	___	8.	Being easily distracted
____	___	9.	Being forgetful
____	___	10.	Having poor planning skills
____	___	11.	Lacking clear goals or forward thinking
____	___	12.	Having difficulty expressing feelings
____	___	13.	Having difficulty expressing empathy for others
____	___	14.	Experiencing excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or “in a fog”
____	___	19.	Feeling fidgety, restless or trouble sitting still
____	___	20.	Having difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Running about or climbing excessively in situations in which it is inappropriate
____	___	22.	Having difficulty playing quietly
____	___	23.	Being always "on the go" or acting as if "driven by a motor"
____	___	24.	Talking excessively
____	___	25.	Blurting out answers before questions have been completed
____	___	26.	Having difficulty waiting for turn
____	___	27.	Interrupting or intruding on others (e.g., butting into conversations or games)
____	___	28.	Behaving impulsively (saying or doing things without thinking first)
____	___	29.	Worrying excessively or senselessly
____	___	30.	Getting upset when things do not go your way
____	___	31.	Getting upset when things are out of place
____	___	32.	Tending to be oppositional or argumentative
____	___	33.	Tending to have repetitive negative thoughts
____	___	34.	Tending toward compulsive behaviors (i.e., things you feel you *must* do)
____	___	35.	Intensely disliking change
____	___	36.	Tending to hold grudges
____	___	37.	Having trouble shifting attention from subject to subject
____	___	38.	Having trouble shifting behavior from task to task
____	___	39.	Having difficulties seeing options in situations
____	___	40.	Tending to hold on to own opinion and not listen to others
____	___	41.	Tending to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or else becoming very upset
____	___	43.	Others complaining that you worry too much
____	___	44.	Tending to say no without first thinking about the question

____ ___45. Tending to predict fear
____ ___46. Experiencing frequent feelings of sadness
____ ___47. Having feelings of moodiness
____ ___48. Having feelings of negativity
____ ___49. Having low energy
____ ___50. Being irritable
____ ___51. Having a decreased interest in other people
____ ___52. Having a decreased interest in things that are usually fun or pleasurable
____ ___53. Having feelings of hopelessness about the future
____ ___54. Having feelings of helplessness or powerlessness
____ ___55. Feeling dissatisfied or bored
____ ___56. Feeling excessive guilt
____ ___57. Having suicidal feelings
____ ___58. Having crying spells
____ ___59. Having lowered interest in things that are usually considered fun
____ ___60. Experiencing sleep changes (too much or too little)
____ ___61. Experiencing appetite changes (too much or too little)
____ ___62. Having chronic low self-esteem
____ ___63. Having a negative sensitivity to smells/odors
____ ___64. Frequently feeling nervous or anxious
____ ___65. Experiencing panic attacks
____ ___66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
____ ___67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
____ ___68. Experiencing periods of troubled breathing or feeling smothered
____ ___69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
____ ___70. Feeling nausea or having an upset stomach
____ ___71. Experiencing periods of sweating, hot flashes, or cold flashes
____ ___72. Tending to predict the worst
____ ___73. Having a fear of dying or doing something crazy
____ ___74. Avoiding places for fear of having an anxiety attack
____ ___75. Avoiding conflict
____ ___76. Excessively fearing being judged or scrutinized by others
____ ___77. Having persistent phobias
____ ___78. Having low motivation
____ ___79. Having excessive motivation
____ ___80. Experiencing tics (either motor or vocal)
____ ___81. Having poor handwriting
____ ___82. Being quick to startle
____ ___83. Having a tendency to freeze in anxiety-provoking situations
____ ___84. Lacking confidence in own abilities
____ ___85. Feeling shy or timid
____ ___86. Being easily embarrassed
____ ___87. Being sensitive to criticism
____ ___88. Biting fingernails or picking at skin
____ ___89. Having a short fuse or experiencing periods of extreme irritability
____ ___90. Having periods of rage with little provocation
____ ___91. Often misinterpreting comments as negative when they are not
____ ___92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
____ ___93. Having periods of spaciness and/or confusion
____ ___94. Experiencing periods of panic and/or fear for no specific reason
____ ___95. Complains of hearing things or seeing things that no one else sees or hears
____ ___96. Having frequent periods of *deja vu* (that is, feelings of having already been somewhere you've never been)
____ ___97. Being sensitive or mildly paranoid
____ ___98. Experiencing headaches or abdominal pain of uncertain origin
____ ___99. Having a history of a head injury or family history of violence or explosiveness
____ ___100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
____ ___101. Experiencing periods of forgetfulness or memory problems