

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 Other POUNOUNS: _____ 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
<u>Occupation:</u>		
<u>Age:</u>		
<u>Highest grade completed:</u>		

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 (e.g. married, divorced, joint custody, sole custody, etc.).

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 | ☐ baby was jaundiced (yellow) |
| ☐ C Section performed | ☐ baby aspirated meconium (breathed waste) |
| ☐ Instruments used to deliver | ☐ baby needed blood |
| ☐ Rh factor present | ☐ baby needed oxygen |
| ☐ breech birth or presentation | ☐ baby had trouble sucking |
| ☐ born with cord around neck | ☐ baby had trouble keeping food down |
| ☐ baby was blue | |
| ☐ 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:

<u>Ages</u>	<u>Ages</u>	<u>Ages</u>
_____ 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	_____ Infections (Meningitis, Encephalitis)	_____ Tics, Twitching
Throats		
_____ Frequent Ear Aches	_____ Major Fractures	Other: _____

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

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Helpful?</u>	<u>Date Started</u>	<u>Side Effects?</u>
			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	_____	_____	_____
Anxiety	_____	_____	_____
Left-handedness (or mixed)	_____	_____	_____
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 ever 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? _____

What was the IEP for?

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

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. 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

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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 <i>must</i> 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