CHILD AND ADOLESCENT HEALTH
PARENT QUESTIONNAIRE

*Please fill out and bring to first appointment

Date: __________
Name:____ **Birth date:** __________ **Age of patient**:_______
Name of person completing this form ______________________________
Relationship to patient ____________________________

Referred by _____________________________________

Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? ☐ Yes ☐ No If yes, explain:

What do you hope to gain from this referral?

MEDICAL HISTORY

Name of Pediatrician or Family Provider ____
Date last physical exam _________________
Last hearing test ______________ **Last vision test** _________________
List any specialists your child sees ____

Medications
Current **prescribed** medications
____
____

Current **over the counter** medications (include herbal medications)
____

Allergies to medications ☐ Yes ☐ No If yes, which one(s) ______________________________________

Medical Conditions your child has had or has been diagnosed:

	Yes	No			Yes	No	
ADHD/ADD				Chronic Headaches			
Anxiety Problems				Head Injury			
Asthma				Seizures			
Broken Bone				Knocked out (loss of consciousness)			
Chronic Ear Infections				Concussion			

Chronic Hearing Loss				Depression			
Stomach Problems/Aches				Fainting			
Weight Problems				Tics			
Diabetes				Bedwetting			
Vision problems							

Other major illnesses, operations, injuries or conditions (please describe and give the year or your age at the time)

____
____

Develomental Disabilities or Challenges (visual, hearing, fine motor, gross motor, speech etc.) If yes, please describe: ____
____

Has your child ever had a MRI brain scan, CT brain scan or EEG? ☐ Yes ☐ No If yes, please explain
____

How does your child sleep? (time fall asleep, duration of sleep, night terrors, frequent awakenings, bedwetting, nightmares, sleep walking etc.)____

How does your child eat? ____

Prolonged separations from mother and/or father: (What age? How long? Child's reaction to separation?) ____

PAST PSYCHIATRIC HISTORY

Has your child ever received psychiatric services or counseling? ☐ Yes ☐ No If yes, please explain and include dates of service, location, provider or counselor's name ___________________________
____
____

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3, then use margins)

Name of Medication	Prescribed by	Dose	Side Effects	% Improvement

Has your child ever threatened or attempted suicide? ☐ Yes ☐ No If yes, please explain
____

CHILD DEVELOPMENTAL HISTORY

Prenatal and Birth History

Adopted? ☐ Yes ☐ No If yes, at what age? ________________

Please check any that apply to the mother's pregnancy with this child:

- ☐ Received prenatal care
- ☐ Took medications
- ☐ Infections
- ☐ Severe emotional distress
- ☐ Nausea and vomiting
- ☐ Weight loss
- ☐ Diabetes of pregnancy
- ☐ Threatened miscarriage
- ☐ Premature labor
- ☐ Smoked during pregnancy
- ☐ Drank alcohol during pregnancy
- ☐ Used drugs during pregnancy

Birthweight _____lb _____oz Was this full term birth? ☐ Yes ☐ No If no, please explain

Apgar scores ____________ Any jaundice? ☐ Yes ☐ No Blue at birth? ☐ Yes ☐ No

Mother's age at time of birth? _______ Father's age at time of birth? _____________

Any complications with the pregnancy? ☐ Yes ☐ No If yes, please explain

Any complications with the delivery? ☐ Yes ☐ No If yes, please explain

Were there any problems after birth? ☐ Yes ☐ No If yes, please explain

Post delivery blues or post-partum depression? ☐ Yes ☐ No If yes, please explain

Breast fed? ☐ Yes ☐ No Food allergies? ☐ Yes ☐ No If yes, please explain

Toddler/Pre-school Temperment: Please check the following that apply.

- ☐ Did not enjoy being held
- ☐ Feeding problems
- ☐ Sensitive to light/noise/texture
- ☐ Excessive restlessness
- ☐ Sleep problems
- ☐ Fussy or unhappy
- ☐ Colic
- ☐ Head-banging
- ☐ Difficulty bonding

Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

Sitting	☐ Normal	☐ Early	☐ Late
Walking	☐ Normal	☐ Early	☐ Late
Speech and Language	☐ Normal	☐ Early	☐ Late
Toilet Trained	☐ Normal	☐ Early	☐ Late
Self- help skills (dressing, brushing, hygiene)	☐ Normal	☐ Early	☐ Late

Unusual Behaviors/Speech Patterns

☐ Spinning ☐ Putting things in the mouth ☐ Sniffing excessively
☐ Hand Flapping ☐ Repeating words or phrases inappropriately ☐ Saying "I" for "You"

School/Daycare History:

Did your child attend daycare? ☐ Yes ☐ No If yes, what was their age? _______ Any problems?
____

What were your child's grades on their last report card? ___________________________________

Have reports cards or school conferences indicated any special difficulty?
☐ Classwork ☐ Behavior ☐ Attitude
Explain: ____

What is the name of your child's primary teacher? _______________________________________

Has your child ever been evaluated for a learning disability? ☐ Yes ☐ No If yes, what grade? ____
When? _____ Learning Disability? ____

IEP (Individual Education Plan) ☐ Yes ☐ No
504 Plan ☐ Yes ☐ No
Placed in Special Education classes? ☐ Yes ☐ No If yes, what type of class or program?
____

Legal/ Juvenile Court

Has your child been:
Arrested ☐ Yes ☐ No
Assigned a probation officer? ☐ Yes ☐ No
Jailed ☐ Yes ☐ No

Has your child:
Ever appeared in juvenile court? ☐ Yes ☐ No
Been assigned a DHR Caseworker? ☐ Yes ☐ No If yes, their name ___________________________

Ever been a victim of child or sexual abuse? ☐ Yes ☐ No

If yes to any of these questions, please explain: ____
____
____

FAMILY MEDICAL HISTORY

☐ Sudden death before 50	☐ Heart Disease	☐ Diabetes
☐ Obesity	☐ Irregular heart rhythms	☐ Seizures
☐ Narrow Angle Glaucoma	☐ Thyroid Problems	☐ Sudden heart attack before 50
☐		

FAMILY PSYCHIATRIC HISTORY

Please tell us if a parent, brother or sister or grandparent has had this problem.

	Yes	No	Who		Yes	No	Who
ADHD/ADD				Learning Disability			
Alcohol Problems				OCD (Obsessive Compulsive)			
Anxiety Problems				Seizures			
Bipolar Disorder				Suicide			
Depression				Tics			
Depression				Tourette's			
Drug Problems				Schizophrenia			

Other ____

SOCIAL/FAMILY HISTORY

Biological mother's full name ____
Biological Father's full name ____
Biological Parent's Marital Status ☐ **Married to each other** ☐ **Divorced** ☐ **Separated**

If divorced from one another, has either remarried? **Father** ☐ **Yes** ☐ **No**
Mother ☐ **Yes** ☐ **No**

If the biological parents are divorced or separated, who has custody of the patient? _______________
Type of custody ____
Stepmother's name ____
Stepfather's name ____

List all individuals that live in the same household as you child:

Name	Relationship	Type of employment/Student Grade Level

Do any of these stressors affect your child at this time?

☐ Family financial problems	☐ Family relationships	☐ Legal problems
☐ Child rearing problems	☐ Drug or alcohol problems	☐ Abuse behavior
☐ Health Problems	☐ Employment problems	☐ School problems
☐ Peer relationships	☐ Frequent change of household	☐ Frequent moving
☐		

Please explain any checked items above and how it affects your child_________________________
____