Valerie L. Andrews, Ph.D.
Clinical Psychologist/Neuropsychologist
408.384.2235
drval@losgatosassessmentcenter.com

PARENT QUESTIONNAIRE

Date _____

The following information is considered important for understanding and effectively evaluating your child. While pertinent information will be included in the summary report, parents may request any of the information shared on this form be kept confidential.

Name of Person filling out this questionnaire: _____

Student's Name _____ Student Lives With _____
Date of Birth _____ Age _____ School Year _____ Left or Right Handed _____

Name of School _____ Contact _____
Address _____ City _____ Zip _____
Phone ( )_____ Fax ( )_____
Teacher _____
School Contact email _____

Mother's Name _____ Date of Birth _____
Home Address _____ City _____ Zip _____
Home Phone ( )_____ Cell Phone ( )_____
Work Phone ( )_____ Fax ( )_____
E-mail Address _____

Father's Name _____ Date of Birth _____
Home Address _____ City _____ Zip _____
Home Phone ( )_____ Cell Phone ( )_____
Work Phone ( )_____ Fax ( )_____
E-mail Address _____

Referral Information
Person responsible for referral _____
Do you have a Counselor for the child? Name: _____
Reason for referral, including questions or problems with which you would like help _____
_____
_____

Family Background
When did you first notice the problem(s), and how has it been demonstrated _____
_____

Is there anyone in your family who exhibits similar social, emotional, or behavioral problems?

_____

_____

Is your child adopted? If so, at what age? _____
Where was the child born? (Place of birth)_____
How has child handled the fact that he/she is adopted? _____

_____

Since your child's birth, has there been: Reaction of child:

_____ a death in the family Who _____ When _____ _____
_____ separation or divorce When _____ _____
_____ remarriage of mother When _____ _____
_____ remarriage of father When _____ _____
_____ number of moves When_____ _____
_____parent illness _____
Other circumstances (e.g. traumatic event, long absence of one parent or sibling) _____

_____

Any known or suspected trauma?_____
Does your child speak any other languages? _____
Religious Affiliation _____
Cultural background of family _____

Please specify ages and circumstances during which any of the following occurred:
When was the last visual exam _____ By whom _____
Vision (20/20) _____
Eye difficulties (glasses, therapy) _____
Ear infections (surgery) _____
Last Hearing exam _____
Allergies or Asthma _____
Sleep Disturbances _____
Seizures _____
Enuresis (bed wetting) _____
Head Injuries (a fall or blow to the head at any time) _____
Was your child unconscious _____
Hospitalizations or other medical problems _____

_____

CHILD MEDICAL HISTORY
Has there been a visit to a Psychiatrist _____ When _____ By whom _____
Results _____
Is your child currently in counseling? _____
When was the last complete physical exam _____
Who performed this exam _____

Pediatrician's Name _____

GP's Name _____
Current medical problems and medications given _____
_____
_____
_____
When diagnosed? _____By Whom? _____
List past medical problems/medications _____
_____
_____
_____

Other doctors/clinics seen regularly _____
_____

Any history of head trauma (describe) _____
_____
Any extreme high fevers or unconsciousness _____
Ever any seizures or seizure-like activity _____
Prior hospitalizations (place, cause, dates, outcome) _____
_____

Abnormal lab tests, x-rays, EEG's, etc. _____
_____
Allergies or drug intolerance (describe) _____
Current vitamins or supplements taken _____
Present height _____ Present weight _____
Is height or weight above or below average? _____

Current Life Stresses
List current factors that are a source of stress in the family _____
_____
_____
_____
Are immunizations current? _____

FAMILY MEDICAL HISTORY

Who lives in the current household with the child (describe relationship to each person)
_____
_____
_____

Current marital situation of parents (relational satisfaction) _____

Family Development (describe all marriages, separations, divorces, deaths, traumatic events, losses, etc.) _____
_____
_____
_____

Sibling's Name _____ Sibling's Age _____
Sibling's Name _____ Sibling's Age _____
Sibling's Name _____ Sibling's Age _____
Sibling's Name _____ Sibling's Age _____
Sibling's Name _____ Sibling's Age _____
Sibling's Name _____ Sibling's Age _____
Sibling's Name _____ Sibling's Age _____

Natural (or adopted) Mother's History (Mother's name _____)

Mother's age_____ Occupation_____ Highest qualification completed _____
Mother's learning problems _____
Mother's behaviour problems _____
Mother's marriages _____
Mother's medical problems _____
Mother's childhood atmosphere (family position, illnesses, abuses, etc.) _____
_____
Has mother ever sought psychiatric treatment Yes No
If yes, for what _____
Mother's alcohol/drug use history _____
Have any of mother's blood relatives ever had any learning problems or psychiatric problems, including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations (describe) _____
_____
_____
_____

Natural (or adopted) Father's History (Father's Name _____)

Father's age_____ Occupation_____ Highest qualification completed _____
Father's learning problems _____
Father's behavior problems _____
Father's marriages _____
Father's medical problems _____
Father's childhood atmosphere (family position, illnesses, abuses, etc.) _____
_____
Has father ever sought psychiatric treatment Yes No
If yes, for what _____
Father's alcohol/drug use history _____
Have any of father's blood relatives ever had any learning problems or psychiatric problems, including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations (describe) _____
_____
_____

Stepmother's or **Stepfather's History** (if applicable, indicate which one)

NAME _____
Age___ Occupation _____Highest qualification completed _____
Learning problems _____
Behaviour problems _____
Marriages _____
Medical problems _____
Childhood atmosphere (family position, illnesses, abuses, etc. _____
_____
Has stepmother/stepfather ever sought psychiatric treatment Yes No
If yes, for what _____
Alcohol/drug use history _____

Child's Siblings (first names, ages, relationship to patient, problems, strengths)
_____
_____
_____

CHILD DEVELOPMENTAL HISTORY

Prenatal Events

Parents' attitude toward pregnancy _____
Conception: planned unplanned
Mother's amount of alcohol and/or other substances used during pregnancy?
What was used? _____

How much? _____
How often? _____
Was mother on any medication during pregnancy?_____
Name of medication _____

Birth and Postnatal Events
Birth weight _____ Length _____ Labor duration (hours) _____
Delivery: Vaginal C-Section Any jaundice Yes No
APGAR scores (if known) _____ Total number of days in hospital _____
Any birth problems (describe any trauma, forceps or complications during child's delivery)
_____
Mother's health after delivery _____ Post-delivery blues (how long) _____
Twin? _____
Who was the primary caregiver for the child during the first year _____

Feeding History Breast-fed Bottle-fed Age weaned _____
Any food allergies or current eating problems (describe) _____
_____

Separations from Mother or Father (describe age, duration, child's reaction)
_____
_____

Toilet Training
Age reached bladder control _____ Bowel control _____
Method used, and ease of training _____
Current problems _____

Sexual Development
Gender identity problems _____
Any physical or sexual abuse (describe) _____
_____

Sleep Behavior (describe anything like sleepwalking, nightmares, recurrent dreams, **current sleep problems** such as getting up or trouble falling asleep) _____
_____

Fears/Phobias _____

Motor Development (please write in your child's age – normal limits are in brackets)

Rolled over [2 mo] _____ Sat without support [5-7 mo] _____
Crawled [5-8 mo] _____ Walked [11-16 mo] _____
Ran well [2 yrs] _____ Rode tricycle [3yrs] _____
Threw ball overhead [4 yrs] _____
What is your child's current level of activity _____
Fine and gross motor coordination _____
Compared to peers _____

Language Development (please write in your child's age – normal limits are in brackets)

Spoke several words besides "dada, mama" [1yr] _____
Named several objects "ball, cup" etc., [15 mo] _____
Put three words together; subject, verb, object [2yrs] _____
Vocabulary Articulation _____ Comprehension _____
Compared to peers _____
Current language problems _____

Social Development (please write in your child's age – normal limits are in brackets)

Smiled [2 mo] _____ Shy with strangers [6-10 mo] _____
Separated from mother easily [2-3 yrs] _____
Cooperative play with others [4 yrs] _____
Quality of attachment to mother _____
Quality of attachment to father _____
Relationship to other family members _____
Early peer interactions _____

How would you describe your child's social interaction? Do you have children over to the house to play? _____
_____
Is child invited to friend's parties? _____

What special interests, hobbies or talents does your child have: _____
_____
_____

What is your child's favorite way to spend free time: _____
_____
_____

Sports or Club activities (with dates) _____
_____
Work? (with dates) _____

Behavioral/Discipline

Compliance vs. non-compliance _____

Lying/stealing _____
Rule breaking _____
Other problems _____
What is the most effective way you discipline your child

_____

_____

Emotional Development
Early temperament _____
Current personality _____
General mood _____ Habits _____
Fears/phobias _____
Special objects (blankets, doll, etc.) _____
Ability to express feelings _____

Alcohol and Drug History
List age started, types of substances used, and any current usage _____

_____
Caffeine use per day
(caffeine is in coffee, tea, soda, chocolate) _____
Nicotine use per day
(nicotine is in cigarettes, chews, etc.) _____

Overall Strengths (from parents' point of view) _____

_____

_____

_____

Overall Strengths (from child/teen's point of view) _____

_____

_____

_____

Child Educational History

Please list the schools your child has attended, including ages, grade and dates. Also please include any specialized assistance (i.e. resource classroom, speech/language therapy, private tutoring).

Age	Year	School/City	Dates	Assistance Needed

Tutoring (please list ANY and ALL) _____
_____
Average School Grade _____
Have there been previous learning evaluations ?_____ When? _____
By Whom? _____
Results? _____
_____

Has your child been held back a year in school?_____
If so, did this have positive benefits or was it a negative experience for your child?
_____

Does your child remember school assignments independently? _____
_____

How much time does your child spend on homework each night? _____

Does your child complete homework/class work assignments on time? _____
_____

How much assistance do you provide at home?
None _____ Occasional _____
Daily _____ Child cannot work alone _____
_____
_____

Have any of the following areas been a hindrance to your child. Please indicate **WHEN** problem began and any specifics. **WHEN:**

Attention/Concentration _____

Misbehavior _____

Handwriting _____

Math _____

Organisation _____

Reading – decoding (sounding out words) _____

Reading – comprehension _____

Written Expression _____

Spelling _____

Auditory Processing _____

Anxiety _____

Nail Biting _____

Depression _____

Bed wetting or soiling _____

Obsessions? _____

Hallucinations? _____

Please indicate when these problems began and if they are current problems.

Any additional comments:

THANK YOU FOR YOUR TIME! Dr Val