# PARENTS' QUESTIONNAIRE

Child's Name ________________________D.O.B. ____________Age_________Sex_______

Home Address _____________________________Phone_____________________________

School ______________________________Grade_______Teacher______________________

Present placement of child (place check in appropriate bracket):

| | **Column A**<br>Adults with whom child is living | **Column B**<br>Non-residential adults involved with child |
|---|---|---|
| Natural mother | (   )________ | (   )_________ |
| Natural father | (   )________ | (   )_________ |
| Stepmother | (   )________ | (   )_________ |
| Stepfather | (   )________ | (   )_________ |
| Other (specify) | (   )________ | (   )_________ |

**Place the number 1 or 2 next to each check in Column A and provide the following information about each person:**

1. Name_________________________________Occupation____________________________

Bus. Name _____________________Bus. Phone________________________________________

Bus. Address ______________________________________________________________________

2. Name__________________________________________Occupation____________________

Bus. Name _____________________Bus. Phone________________________________________

Bus. Address ______________________________________________________________________

3. Name__________________________________________Occupation______________________

Bus. Name _____________________Bus. Phone__________________________________________

Bus. Address ________________________________________________________________________

**Place the number 3 next to the person checked in Column B who is most involved with the child and provide the following info.:**

**Who referred you to Dr. Pray?**_______________________________________________

Address_______________________________________Phone ___________________________

Purpose of consultation (brief summary of the main problem):

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**PREGNANCY**

**Complications:**

Excessive vomiting______ Hospitalization required_________
Excessive staining or blood loss______ Toxemia_____
Threatened miscarriage_______
Infection(s) (specify)_________________________________
Operation(s) (specify) ________________________________
other illness(es) (specify) _______________________________
Smoking during pregnancy_________ average number cigarettes/day ____________
Alcohol consumption during pregnancy_______ Describe_______________________________
other non-prescription drug use during pregnancy ________ Describe ________________________
Prescription medications taken during pregnancy _________________________________________
X-ray studies during pregnancy Duration (weeks) ____________________________________

**DELIVERY**

Type of labor: Spontaneous_____________ Induced _________________
Duration of labor:_________ hours
Type of delivery: Vertex (normal) ______Caesarean _________ Breach ___________

**Complications?___________________________**

Birth Weight?
Appropriate for gestational age (AG)________ Small for gestational age (SGA) ______

**POST-DELIVERY PERIOD** (while in the hospital)

Respiration: Immediate_________ Delayed (if so, how long) ________________
Cry: Immediate_____________ Delayed (if so, how long) _________________
Mucous accumulation ___________ Apgar score (if known)________________
Jaundice___________ Incubator care ________________
Suck: Strong _________Weak _______________
Infection (specify)_______________________________________________
Vomiting__________ Diarrhea____________________
Birth defects (specify)______________________________________________________

**INFANCY-TODDLER PERIOD**

Were any of the following present to a significant degree during the first few years of life? If so, describe.

Did not enjoy cuddling ______________________________________________________________
Was not calmed by being held and/or stroked ___________________________________________
Colic_________________________________________________________________________
Excessive restlessness_________________________________________________________
Frequent headbanging__________________________________________________________
Excessive number of accidents compared to other children__________________________________

**DEVELOPMENTAL MILESTONES**

Please note if each milestone occurred Early, At the Normal Time, or Late, to the best of your recollection.

Smiled ___________________________________________________________________
Sat without support________________________________________________________
Stood without support______________________________________________________
Walked without assistance___________________________________________________
Spoke first words besides "ma-ma" and "da-da" _______________________________
Said phrases______________________________________________________________
Said sentences_____________________________________________________________
Bowel trained, daytime______________________________________________________
Bowel trained, nighttime____________________________________________________
Bladder trained, daytime____________________________________________________
Bladder trained, nighttime___________________________________________________
Rode tricycle ______________________________________________________________
Rode bicycle (without training wheels) ____________________________________
Buttoned clothing__________________________________________________________
Tied shoelaces_____________________________________________________________
Named colors______________________________________________________________
Said alphabet in order______________________________________________________
Began to read______________________________________________________________

**COORDINATION**

Rate your child on the following skills:

| | **Good** | **Average** | **Poor** |
|---|---|---|---|
| Walking | | | |
| Running | | | |
| Throwing | | | |
| Catching | | | |
| Shoelace tying | | | |
| Buttoning | | | |
| Writing | | | |
| Athletic abilities | | | |

**COMPREHENSION AND UNDERSTANDING**

Do you consider your child to understand directions and situations as well as other children his or her age?_______________________________

If not, why not?_____________ __________________________________________

How would you rate your child's overall level of intelligence compared to other children? (next pg)

Below average________ Average_________ Above average___________

**SCHOOL**

**Rate your child's school experiences related to academic learning:**

| | **Good** | **Average** | **Poor** |
|---|---|---|---|
| Kindergarten | | | |

Primary School ______________________________________________________________
Intermediate School ____________________________________________________________
College/Secondary_______________________________________________________________
To the best of your knowledge, at what grade level is your child functioning:
Reading______ Spelling________ Arithmetic_______
Has you child ever had to repeat a year?_________ When?_________________________
Present class placement: Regular class__________ Special Class____________________
(if so, specify)
Kinds of special therapy or remedial work your child is currently
receiving:____________________________________________________________
Describe briefly any academic school
problems_______________________________________________________________

**Rate your child's school experience related to behavior:**

| | **Good** | **Average** | **Poor** |
|---|---|---|---|
| Kindergarten | | | |
| Primary | | | |
| Intermediate | | | |
| Current grade | | | |

Does your child's teacher describe any of the following as a significant classroom problem?
Doesn't sit still in his or her seat____________________
Frequently gets up and walks around the classroom_______________________
Shouts out; doesn't wait to be called upon __________________________________
Won't wait his or her turn _____________________________________________
Does not cooperate in group activities ______________________________
Typically does better in a one-to-one relationship________________________
Doesn't respect the rights of others_____________________________________
Doesn't pay attention during storytelling______________________________
Describe briefly any other classroom behavior
problems_______________________________________________________________
________________________________________________________________________

**PEER RELATIONSHIPS**

Does your child seek friendships with peers? _________________________________
Is your child sought by peers for friendship? _________________________________
Does your child play primarily with children his or her own age?____ younger____ older________
Describe briefly any problems your child may have with peers
________________________________________________________________________
________________________________________________________________________

**HOME BEHAVIOR**

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his/her age.

Hyperactivity (high activity level)_______
Poor attention span_____________

Impulsivity (poor self control)__________
Temper outbursts________________
Sloppy table manners___________
Interrupts frequently_____________
Doesn't listen when being spoken to___________
Sudden outburses of physical abuse of other children____________
Acts like he or she is driven by a motor __________________
Wears out shoes more frequently than siblings __________________
Ignores danger ___________________
Excessive number of accidents __________________
Doesn't learn from experience _________________
Poor memory___________________________________
More active than siblings_________________________

**INTERESTS AND ACCOMPLISHMENTS**

What are your child's main hobbies and interests?

What are your child's areas of greatest accomplishment?

What does your child enjoy doing most?

What does your child dislike doing most?

**MEDICAL HISTORY**

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications)________________________________________
________________________________________________________________________________
Operations_______________________________________________________________________
________________________________________________________________________________
Hospitalizations for illness(es) other than operations_______________________________________
________________________________________________________________________________
Head injuries
With unconsciousness_____________________ without unconsciousness ________________
Convulsions____________________________________________________________________
with fever ___________ without fever __________________
Coma Meningitis or encephalitis ________________________
Immunization reactions _______________________________
Persistent high fevers _______________________________
Eye problems _________________________________________
Ear problems __________________________________________
Poisoning ____________________________________________

**PRESENT MEDICAL STATUS**

Present height ____________ Present weight________________

Current Illness(es) for which child is being treated ________________________________
Medications child is taking (dosage?)________________________________________________
________________________________________________________________________________

**FAMILY HISTORY-MOTHER**
Age ________Age at time of pregnancy with patient ______________
Number of previous pregnancies _________
School: Highest grade completed__________ Learning problems (specify)____________________
Medical problems (specify) _________________________________________________________
________________________________________________________________________________
Have any of mother's blood relatives (not including patient and siblings) ever had problems similar to those your child has?______ If so, describe __________________________________________
________________________________________________________________________________

**FAMILY HISTORY-FATHER**
Age_______ Age at time of the patient's conception ___________________
School: Highest grade completed ____________ Learning problems (specify) _______________
Medical problems (specify)__________________________________________________________
________________________________________________________________________________
Have any of father's blood relatives (not including patient and siblings) ever had problems similar to those your child has? _____ If so, describe ______________________________________________
________________________________________________________________________________

**SIBLINGS**

| Name | Age | Medical, social, or learning problems |
|---|---|---|

l. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________
5. ____________________________________________________________________________

**LIST NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED ABOUT YOUR CHILD:**
l. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________

**ADDITIONAL REMARKS**
Please use the remainder of this page to write any additional comments you wish to make regarding your child’s difficulties: