

Pediatric Behavioral Health
Parent Questionnaire for Ages 0-5

Directions: This form is very important to help with the interview and evaluation process. Not all questions apply to all families; just answer questions as best as they apply to your family. Your answers will help us to better address your child's needs and to better understand your child.
Thank You.

Demographic Information:

Today's Date: _____

Child's Name: _____

Child's Sex: Male Female

Child's Date of Birth: _____

Child's Age: _____

Child's Address: _____

Child's Race: _____ Height: _____ Weight: _____

Mother: Biological Mother; Adoptive Mother; Step-Mother; Custodial Parent

Name: _____ Age: _____

Occupation: _____ Education: _____

Marital Status: _____ Date of Marriage: _____

Address (if different): _____ Cell Phone: _____

Father: Biological Father; Adoptive Father; Step-Father; Custodial Parent

Name: _____ Age: _____

Occupation: _____ Education: _____

Marital Status: _____ Date of Marriage: _____

Address (if different): _____ Cell Phone: _____

Significant Other Adult in Child's Life (step-parent, live-in adult):

Name: _____ Age: _____

Relationship to child: _____

Occupation: _____ Education: _____

Significant Other Adult in Child's Life (step-parent, live-in adult):

Name: _____ Age: _____

Relationship to child: _____

Occupation: _____ Education: _____

Child's Primary Care Doctor:

Name: _____ Phone: _____

Address: _____

Sibling Information:

Name: _____ Age: _____ Full Half Step Adopted

Name: _____ Age: _____ Full Half Step Adopted

Name: _____ Age: _____ Full Half Step Adopted

Name: _____ Age: _____ Full Half Step Adopted

List all people with whom the child lives: _____

Has your child ever received Early Intervention services? YES NO

If Yes, when?: _____

What services did your child receive? (check all that apply):

- Speech therapy Occupational Therapy Physical Therapy
 Play Group Applied Behavioral Analysis (ABA)
 Floor Time Other: _____

School Testing: (CORE, Psychological, Educational, Speech/Language, OT or PT)

Date of Evaluation	Type of Testing	Results

Is your child currently enrolled in public preschool? YES NO

If Yes, When did he/she begin: _____

Name of School: _____

School Address: _____ Phone: _____

Primary Teacher's Name: _____

Type of Classroom: Regular Education Integrated Classroom Specialized Class

Is your child currently enrolled in private preschool? YES NO

If Yes, When did he/she begin: _____

Name of School: _____

School Address: _____ Phone: _____

Primary Teacher's Name: _____

Does your child have an IEP (Individual Education Plan)? YES NO

If Yes, What services does your child receive? (check all that apply)

- Speech therapy Occupational Therapy Physical Therapy
 Applied Behavioral Analysis (ABA) Classroom Aide
 Other: _____

Other Evaluations: (Psychological, Developmental, Neurologist, Specialty Doctor)

Date of	Type of Testing	Results

Medical Tests: (MRI, Genetic Testing, EEG, etc.)

Date	Type of Testing	Results

Has your child received private counseling?

Therapist Name	Dates of Service

Has your child taken medication for attention, behavior or emotional problems? YES NO

Medication (e.g., Ritalin LA)	Dosage (e.g., 20mg)	Start Date	Stop Date	Effects or Adverse Effects

Additional Services or Case Management through an agency? (e.g., DSS, DMH, DMR, etc.)

Agency Name	Type of Service

Health History:

Pregnancy, Labor and Delivery: Explain any yes answers.

	YES	NO	Comments
Age of Mother when child was born? Age _____			
Is this child a twin or multiple birth?			
Any problems with other pregnancies? Miscarriages?			
Were there any problems during this pregnancy?			
Amniocentesis or other fetal health tests (e.g., AFP)?			
Any medications prescribed?			
Gestational diabetes?			
Any problems with blood pressure or toxemia?			
Any problems with infections (including herpes)?			
Smoking during pregnancy?			#packs? _____
Drinking Alcohol during pregnancy?			Amount _____

	YES	NO	Comments
Drugs Taken? (marijuana, cocaine, etc.)			
Problems during labor or delivery?			
Cesarean Delivery? Why?			
Baby born at _____ weeks.			

Newborn History:

	YES	NO	Comments
Birth weight? _____ lbs., _____ oz.			
Were there any problems at birth or as a newborn?			
Were any birth defects or birth injuries noted?			
Put in Special Care or Intensive Care?			
Jaundice and need phototherapy?			
Very jittery or lethargic as newborn?			
Any extra stay in hospital needed?			

Early Infancy:

Describe your child as an infant or toddler?

Infant Temperament

	YES	NO	Comments
Problems with feeding in infancy?			
Severe or prolonged colic or excessive crying?			
Difficult temperament (irritable or demanding)?			
Excessively wiggly or active as and infant or toddler?			
Easily over-stimulated as infant or toddler?			
Passive, shy or withdrawn as infant or toddler?			
Liked to be held or cuddled?			

Medical History

	YES	NO	Comments
Problems with vision? Crossed eyes? Wears glasses?			
Problems with hearing?			
Serious or chronic health problems (e.g., diabetes)			
Birth defect or birthmarks?			
Hospitalizations or surgery?			
Serious infections or illness (e.g., meningitis?)			
Serious injury, burn or broken bones?			
Head injury or lost consciousness?			
Frequent accidents or multiple minor injuries?			
Fainting spells or dizziness?			

	YES	NO	Comments
Seizures, convulsions or staring spells?			
Motor tics (blinking, squinting, head tossing)?			
Vocal tics (sniffing, grunting, throat clearing, noises)?			
Compulsive mannerisms (hand washing, picking, lining things up, counting)			
Frequent headaches? Migraines?			
Serious ear infections? Chronic antibiotics or ear tubes?			
Serious nose, mouth or throat problems?			
Thyroid disorders or other hormone problems?			
Respiratory or lung problems (pneumonia, asthma)?			
Frequent Stomach aches?			
Problems with diarrhea, constipation or vomiting?			
Problems with kidneys, bladder or urine?			
Blood problems or anemia (iron deficiency or low blood count)?			
Poisoning or exposure to toxic chemicals (e.g., lead)?			
Unusual reaction or immunizations?			
History or suspicion of physical or sexual abuse?			
Problems with restless sleep or snoring?			
Difficulties with eating, diet, or appetite?			
Small for age or very underweight?			
Over eats or overweight?			
Allergies to medications? Specify			
Other allergies? Specify			
Vitamin Supplements? Specify			
Herbal medicines or other nutritional supplements?			
Any non-medical treatments (diet, chiropractic, acupuncture)?			
Any prescribed medications? Specify			

Developmental History:

Developmental Milestones:

	YES	NO	Too Young
Sit by 8 months?			
Crawl by 10 months?			
Walk by 15 months? Age: _____ months			
Speak in 2 word sentences by 2 years?			
Could strangers understand your child by 3 years?			
Toilet trained during the day by 3 ½ years?			
Dry at night by 5 years?			

Developmental Difficulties:

	YES	NO	Too Young
Day or night time wetting? Accidents?			
Stool / bowel accidents? (e.g., soiling)			
Difficulty falling asleep or bedtime behavior?			
Difficulty staying asleep or staying in bed at night?			
Difficulty waking up in the morning?			
Difficulty with feeding self?			
Difficulty with dressing?			
Difficulty learning to throw and catch a ball?			
Difficulty learning to name colors or shapes?			
Difficulty learning to name letters or numbers?			
Difficulty learning to ride a tricycle or bicycle?			

Does your child seem to develop normally but then lose developmental skills? YES NO

If Yes, describe? _____

Current Developmental Skills:

	Above Average	Average	Below Average	Too Young
Ability to understand spoken words (receptive language)				
Pronounces words clearly (Articulation)				
Ability to talk and use good sentences (Expressive language)				
Conversation skills (turn taking; uses polite language)				
Ability to use fingers to write or draw (Fine Motor)				
Ability to use large muscles to run or play sports				

Comments on developmental Skills: _____

Social Development:

Check ALL which describe your child socially:

- _____ Other children seek him/her out for play
- _____ S/he seeks out other children for play
- _____ S/he prefers to play alone
- _____ Lots of children like him/her, AND few children dislike him/her

- Lots of children like him/her, BUT lots of children don't like him/her
- Other children pretty much ignore my child
- My child fights a lot with other children
- My child often plays cooperatively with other children

How many friends does your child have around his home? _____

How much time does your child play with those friends per day? _____

How many friends does your child have at school? _____

How much time does your child play with those friends per day? _____

Does your child have a best friend? YES NO

If yes, what is the best friend's first name _____

How does your child get along with non-parent adults (check all that apply)?

- | | |
|--|---|
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Better behaved than with parents |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Adults like my child |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Obedient |
| <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Other _____ |

How does your child get along with teachers / day care providers / coaches?

- | | |
|--|---|
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Better behaved than with parents |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Adults like my child |
| <input type="checkbox"/> Disobedient | <input type="checkbox"/> Obedient |
| <input type="checkbox"/> Disrespectful | <input type="checkbox"/> Other _____ |

How does your child get along with brothers and sisters?

- | | |
|--|--|
| <input type="checkbox"/> Likes them | <input type="checkbox"/> Protective of them |
| <input type="checkbox"/> They like him/her | <input type="checkbox"/> Aggressive / Fights |
| <input type="checkbox"/> Jealous | <input type="checkbox"/> Won't share things |
| <input type="checkbox"/> Ignores them | <input type="checkbox"/> Wants to be babied |
| <input type="checkbox"/> Other _____ | |

How much time per day does your child spend watching TV? _____

How much time per day does your child spend on computer / video games? _____

For office use only:

- | | | | | |
|---------------------------------|-----------------------------------|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Mullen | <input type="checkbox"/> ASD | <input type="checkbox"/> Gillian | <input type="checkbox"/> BASC-2 | <input type="checkbox"/> EI Evaluation |
| <input type="checkbox"/> CARS | <input type="checkbox"/> Conner's | <input type="checkbox"/> Vineland | <input type="checkbox"/> Teacher | <input type="checkbox"/> School Evaluation |

Family Background

1. List marriages of biological MOTHER (past and present):

Spouse's Name	Marriage Date	Children's Names	Divorce Date	Reason for Divorce
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. List marriages of biological FATHER (past and present):

Spouse's Name	Marriage Date	Children's Names	Divorce Date	Reason for Divorce
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Please indicate if the following have occurred in the family:

	Date(s)	Description / Comments
Divorce	_____	_____
Separation	_____	_____
Marital Problems	_____	_____
Domestic Violence	_____	_____
Excessive Conflict	_____	_____
Death of Parent	_____	_____
Death of Child	_____	_____
Death of Grandparent	_____	_____
Alcohol Abuse by Parent	_____	_____
Drug Abuse by Parent	_____	_____
Move to New Home	_____	_____
Physical or Sexual Abuse	_____	_____
Illness of Family Member	_____	_____
Other Changes	_____	_____

4. How is discipline handled in the family?

5. Who is most responsible for discipline? Mother Father Both

6. Describe your relationships with the following extended family members.

- | | | | | |
|-----------------------|-----------|------|------|------|
| a. Father's Parents: | Excellent | Good | Fair | Poor |
| b. Mother's Parents: | Excellent | Good | Fair | Poor |
| c. Father's Siblings: | Excellent | Good | Fair | Poor |
| d. Mothers' Siblings: | Excellent | Good | Fair | Poor |
| e. Child's Cousins: | Excellent | Good | Fair | Poor |
| f. Other _____: | Excellent | Good | Fair | Poor |

7. Family Religion: _____

4. Does anyone in the child's immediate or extended family have the following illnesses or problems? Include brothers, sisters, father, mother, grandparents, aunts, uncles, cousins.

<u>Illness</u>	<u>Circle Y or N</u>		<u>Relationship to the Child (i.e., aunt, father, etc.)</u>
Depression	Y	N	_____
Manic Depression	Y	N	_____
Nervous Breakdown	Y	N	_____
Psychiatric Hospitalization	Y	N	_____
Delayed Reading	Y	N	_____
Delayed Speech	Y	N	_____
Mental Retardation	Y	N	_____
Attention Problems	Y	N	_____

Hyperactivity	Y	N	_____
Heavy Drinking	Y	N	_____
Drug Abuse	Y	N	_____
Suicide	Y	N	_____
Stealing	Y	N	_____
School Phobia	Y	N	_____
Epilepsy	Y	N	_____
Felony Conviction	Y	N	_____
<u>Illness</u>	<u>Circle Y or N</u>		<u>Relationship to the Child (i.e., aunt, father, etc.)</u>
Anxiety Disorder	Y	N	_____
Schizophrenia / Psychosis	Y	N	_____
Autism / Asperger's Disorder	Y	N	_____
Eating Disorder	Y	N	_____
Insomnia	Y	N	_____
Any Genetic Disorder	Y	N	_____
Other _____	Y	N	_____

Social History:

Please provide any additional information that you think would be helpful.