



2200 Harvard Road, Suite 101
Lawrence, KS. 66049
Phone: (785) 842-0656
Fax: (785) 842-0071

Parent Questionnaire

814 High, Suite A • PO Box 368
Baldwin City, KS 66006
Phone: (785) 594-3162
Fax: (785) 594-3257



Full Name of Child: _____ DOB: _____ Age: _____ Sex: _____
Address: _____ Phone: _____
Referred by: _____

FAMILY HISTORY

Father's Name: _____ Home Number: _____ Work Number: _____
Address: _____ Occupation: _____
Mother's Name: _____ Home Number: _____ Work Number: _____
Address: _____ Occupation: _____
Child lives with: 1 parent 2 parents. Are there other adults in the home? yes no If so, how many? _____
Siblings and ages: _____

MEDICAL HISTORY

Child's Pediatrician or Family Doctor: _____ Phone: _____
Address: _____

Please list any other doctors, clinics or therapists that have examined this child:

<u>Name</u>	<u>Address</u>	<u>Purpose of Examination</u>
_____	_____	_____
_____	_____	_____

During treatment food or candy is occasionally used. May we give your child food and/or candy? yes no
Does your child have any food allergies/special diet? _____

Have any of the following occurred recently or in the past in the child's life?
 new sibling ill sibling or parent recent death divorce new marriage
 trauma such as auto accident, assault, bullying, sexual abuse, etc. natural disaster such as fire, tornado, flood, etc.

If any of the above boxes were marked, please provide dates and any additional information regarding the event: _____

BIRTH HISTORY

At what week of pregnancy was your child born? _____ Birth Weight: _____ Length: _____

Any unusual occurrences during pregnancy/delivery? yes no If yes, please explain: _____

What medication did child's mother take during pregnancy? (include vitamins and iron): _____

Was child born by C-section? yes no If Yes, please give reason for C-section: _____

Approximately how long was mother in labor? _____ What was baby's condition at birth? _____

Has the child ever had the following?

Eye or vision problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Strain on urination	<input type="checkbox"/> yes <input type="checkbox"/> no
Ear or hearing problems	<input type="checkbox"/> yes <input type="checkbox"/> no	Vomiting spells	<input type="checkbox"/> yes <input type="checkbox"/> no	Surgeries	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma/Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	Frequent diarrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	Musculoskeletal Problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Convulsions or "spells"	<input type="checkbox"/> yes <input type="checkbox"/> no	Frequent cold	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice	<input type="checkbox"/> yes <input type="checkbox"/> no
Head injury	<input type="checkbox"/> yes <input type="checkbox"/> no	Meningitis	<input type="checkbox"/> yes <input type="checkbox"/> no	GERD/Reflux	<input type="checkbox"/> yes <input type="checkbox"/> no

If yes, please explain: _____

Has child had any other health problems not listed above? (Describe): _____

Child's name: _____

Does child take medication on a regular basis? yes no If Yes, please list medication taken and amount: _____

Please list below the name of the hospital where your child was born. Has child ever been hospitalized? Please list below:

<u>Hospital</u>	<u>Address</u>	<u>Year</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEVELOPMENT & SCHOOL HISTORY

At what age did your child first:

- | | | |
|----------------------------|---------------------------------|------------------------------|
| Hold head up _____ | Walk with help _____ | Feed self finger foods _____ |
| Reach for objects _____ | Walk alone _____ | Use single words _____ |
| Sit alone _____ | Dress self _____ | Use groups of words _____ |
| Crawl (hands & feet) _____ | Completely toilet trained _____ | Use sentences _____ |
| Stand alone _____ | Babble and coo _____ | |

Is child currently enrolled in a school program? yes no If Yes, please answer the following: Grade: _____

School Name: _____ Address: _____

Has child been evaluated by school diagnostic team? yes no If Yes, when was evaluation completed? _____

Please describe child's performance at school. What subjects does he/she do well in; what subjects does he/she have difficulty with?

Does child receive any special services to help him/her at school? (Describe): _____

Present Case Manager/Therapist/Teacher _____

Is there a current IFSP/IEP? yes no Date of next review: _____

Current School Programming/Services: _____ Current Schedule: (#of days/week) _____

NOTE: If possible, please bring a copy of your child's IFSP/IEP.

GENERAL BEHAVIOR

Does your child: Sit and listen for long periods? yes no Follow verbal directions? yes no

Does your child engage in any self injurious activities? yes no If so, please explain: _____

Please list your child's favorite play activities: _____

What are your child's strengths/assets? _____

What are your child's most frequent behavior problems? _____

How do you resolve them? _____

When upset, how is your child best calmed? _____

Does your child have regular playmates or friends? yes no

Please describe the major concerns you have in seeking help for your child. List concerns in order of their importance.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Is there anything else you would like us to know about your child? _____

Person completing this form: _____ Relation to child: _____

Parent/Guardian Signature: _____ Date: _____

Thank your for this information! You know your child best and we appreciate your input!