Pre-visit Questionnaire: Evaluation of Academic/Behavior Concerns

Name of Child: _____ Date of Birth: _____

Child's Preferred Name: _____ Preferred Pronouns: _____

Date completed: _____ Completed by: _____ Relationship to child: _____

CONCERNS:
Briefly list concerns (academic, behavioral, social, or emotional) about your child. Rank priority first.

At what age did your child first have these problems? _____

Check areas of your child's life impacted by these concerns: ☐ School ☐ Home ☐ Social ☐ Activities

STRENGTHS:
Please list your child's strengths, abilities, accomplishments:

FAMILY INFORMATION:
Primary Household:

- Parent / Caregiver: Name: _____ DOB: _____
  Relationship to Patient: _____ Job (if employed): _____
- Parent / Caregiver: Name: _____ DOB: _____
  Relationship to Patient: _____ Job (if employed): _____
- Siblings? (names, ages) _____
- Other adults/children living at home? (names, relationships to child):
  _____

Secondary Household: ☐ Yes ☐ No

- Parent / Caregiver: Name: _____ DOB: _____
  Relationship to Patient: _____ Job (if employed): _____
- Parent / Caregiver: Name: _____ DOB: _____
  Relationship to Patient: _____ Job (if employed): _____
- Siblings? (names, ages) _____
- Other adults/children living at home? (names, relationships to child):
  _____

SOCIAL DETERMINANTS OF HEALTH:

Do any of the following apply to your child's living situation? ☐ Yes ☐ No

- Recent major changes or stresses in the child's family or home life
- A household member is experiencing depression or other mental illness
- A household member has a problem with drinking or drugs
- Parents/caregivers are separated, divorced, or experiencing marital stress
- More than once went without food, clothing, or a place to live

Since birth, have any of the following applied to your child? ☐ Yes ☐ No

- Experienced violence in the home, neighborhood, or school
- Treated badly because of race, sexual orientation, place of birth, disability, or religion
- Experienced harassment or bullying
- Child experienced physical, emotional, sexual abuse, or neglect
- Child was in foster care
- Child was separated from parent(s) through immigration/deportation
- Parent or guardian died
- A household member had a serious medical procedure or life-threatening illness
- A household member has served time in jail or prison

PAST MEDICAL HISTORY:

Birth History:

- Did birth mother use any of the following during pregnancy?
  - Cigarettes/Vaping: ☐ Yes ☐ No
  - Alcohol: ☐ Yes ☐ No
  - Street drugs: ☐ Yes ☐ No
  - Prescribed medicine(s): ☐ Yes ☐ No
- Premature birth? ☐ Yes ☐ No How early? _____ weeks gestation
- Where was child born? _____

Cardiac History:

- Congenital heart disease? ☐ Yes ☐ No
- Arrhythmia? ☐ Yes ☐ No

Medications:

- Current prescription medications: _____
- Current daily over-the-counter medications/supplements: _____

Psychiatric History:

Has your child been diagnosed with any of the following? *If yes, please submit the medical records or neuropsychology evaluation report via portal.*

- Anxiety/OCD/depression: ☐ Yes ☐ No
- Disordered eating or body image: ☐ Yes ☐ No
- ADHD: ☐ Yes ☐ No
- Learning difference: ☐ Yes ☐ No
  - If yes: ☐ Reading / Dyslexia ☐ Writing / Dysgraphia ☐ Math / Dyscalculia ☐ Auditory Processing

SCHOOL:

1. Academic:

- Is your child below grade level? ☐ Yes ☐ No
- Does teacher raise concerns about progress? ☐ Yes ☐ No
- Struggles or gets extra help in:
  Reading? ☐ Yes ☐ No Math? ☐ Yes ☐ No Writing? ☐ Yes ☐ No
- Does your child have an IEP or 504 Plan? ☐ Yes ☐ No

SCHOOL (Continued):

What contributes to learning difficulties?

- Not paying attention in class ☐Yes ☐No
- Not finishing all homework ☐Yes ☐No
- Homework late or lost ☐Yes ☐No
- Does not study for tests ☐Yes ☐No
- Rushed, careless, doesn't proofread ☐Yes ☐No
- Does not understand material ☐Yes ☐No

2. Behavior:

- Ignores or disobeys rules? ☐Yes ☐No
- Disrupts classroom? ☐Yes ☐No
- Can't sit still? ☐Yes ☐No
- Disrupts other children? ☐Yes ☐No

SOCIAL:

- Few or no friends? ☐Yes ☐No
- Few party invites/playdates? ☐Yes ☐No
- Prefers younger/older kids? ☐Yes ☐No
- Immature compared to peers? ☐Yes ☐No
- Does not have one good friend? ☐Yes ☐No
- Makes friends but loses them? ☐Yes ☐No
- Doesn't read social cues? ☐Yes ☐No
- "In your face"? ☐Yes ☐No
- Inappropriate touching? ☐Yes ☐No
- Competitive or needs to win? ☐Yes ☐No

INTERESTS & ACTIVITIES: _____

MEDIA USE: _____

EXECUTIVE FUNCTION:

Focus and Distractibility:

- Inattentive during non-school activities? ☐Yes ☐No
- Problems with transitions? ☐Yes ☐No
- Does your child daydream a lot? ☐Yes ☐No
- Difficulty with multiple instruction? ☐Yes ☐No
- Distracted easily during homework? ☐Yes ☐No

Activation:

- Appears unmotivated to work? ☐Yes ☐No
- Procrastinates with non-preferred tasks? ☐Yes ☐No

Effort:

- Hard to sustain effort on some tasks? ☐Yes ☐No
- Gives up easily or "shuts down"? ☐Yes ☐No

Memory:

- Loses and misplaces things? ☐Yes ☐No
- Forgets things at school? ☐Yes ☐No
- Doesn't learn from experience? ☐Yes ☐No

Emotion:

- Has big reactions to small triggers? ☐Yes ☐No
- Has "meltdowns"? ☐Yes ☐No

Activity/Impulsivity:

- Hyperactive? ☐Yes ☐No
- Fidgety or wiggly? ☐Yes ☐No
- Does your child talk excessively? ☐Yes ☐No
- Problems interrupting? ☐Yes ☐No
- Problems blurting out? ☐Yes ☐No
- Do you avoid going out with your child? ☐Yes ☐No

EXECUTIVE FUNCTION (Continued):

Organization / Time management / Planning:

- Many missing/late assignments? ☐Yes ☐No
- Easily overwhelmed by projects? ☐Yes ☐No

ADDITIONAL CONCERNS:

Sleep problems:

- Trouble falling asleep? ☐Yes ☐No
- Trouble sleeping alone? ☐Yes ☐No
- Trouble staying asleep? ☐Yes ☐No
- Restless sleep? ☐Yes ☐No
- Snoring or mouth breathing? ☐Yes ☐No
- Hard to awaken? ☐Yes ☐No

Self-esteem:

- Does your child have poor self-esteem? ☐ Yes ☐No

Mood:

- Child acts sad or down? ☐ Yes ☐No
- Child acts irritable/angry often? ☐ Yes ☐No
- Child has been withdrawn? ☐ Yes ☐No
- Child is no longer interested in things they enjoy? ☐ Yes ☐No

Anxiety:

- Child has excessive worries/fears? ☐ Yes ☐No
- Has frequent headaches? ☐ Yes ☐No
- Has frequent stomach aches? ☐ Yes ☐No
- Has panic attacks? ☐ Yes ☐No
- Tries to avoid going to school? ☐ Yes ☐No
- Has difficulty meeting new people? ☐ Yes ☐No
- Has trouble leaving parents? ☐ Yes ☐No
- Must check/clean/organize to feel OK? ☐ Yes ☐No
- Gets “stuck on thoughts”? ☐ Yes ☐No
- Asks for reassurance frequently? ☐ Yes ☐No

Oppositional or defiant behaviors:

- Problems with obedience/compliance? ☐ Yes ☐No
  - Oppositional or defiant? ☐ Yes ☐No
- Does your child lie? ☐ Yes ☐No
- Does your child steal? ☐ Yes ☐No
- Ever been involved in antisocial behavior:
  - Setting fires? ☐ Yes ☐No
  - Breaking and entering? ☐ Yes ☐No
  - Physical violence with weapon? ☐ Yes ☐No
  - Cruelty to animals or peers? ☐ Yes ☐No
- Contact with police/juvenile authority? ☐ Yes ☐No

ADDITIONAL CONCERNS (Continued):

Communication / Regulation:

- Trouble reading social cues/facial expression/body language? ☐Yes ☐No
- Problems with peer relationships? ☐Yes ☐No
- Intensely focused on a limited number of interests? ☐Yes ☐No
- Sensory issues (sound, touch, smell, texture, picky eater)? ☐Yes ☐No
- Repetitive behaviors (hand flapping, repeating phrases) or speech? ☐Yes ☐No
- Insist on special routines and upset if not followed? ☐Yes ☐No

Tics:

- Does your child have a muscle tic? ☐Yes ☐No
- Does your child make repetitive vocal noises? ☐Yes ☐No

Substance Abuse:

- Does your child drink alcohol, vape, or use any substances? ☐Yes ☐No

INTERVENTIONS: What have you already done to try to help?

Prior evaluation(s) _____

Tutoring _____

Counseling _____

Parent Coaching _____

Therapies:

- Occupational therapy (OT) ☐Yes ☐No
- Physical therapy (PT) ☐Yes ☐No
- Speech therapy ☐Yes ☐No
- Social skills ☐Yes ☐No

FAMILY HISTORY: List person affected and relationship to child.

- ADHD: ☐Yes ☐No _____
- Learning disability: ☐Yes ☐No _____
- Anxiety: ☐Yes ☐No _____
- OCD: ☐Yes ☐No _____
- Depression: ☐Yes ☐No _____
- Bipolar: ☐Yes ☐No _____
- Autism: ☐Yes ☐No _____
- Abnormal heart rhythm? ☐Yes ☐No Needed a pacemaker? ☐Yes ☐No _____
- Substance abuse: ☐Yes ☐No _____

GOALS:

What are your goals for your child? *Rank top priorities and limit to no more than 5 (may list fewer).*

1. _____
2. _____
3. _____
4. _____
5. _____