



Pre-visit Parent Questionnaire: Evaluation of Academic/Behavior Concerns

Name of Child: _____ Date of Birth: _____

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 most impacted by these concerns: School Home Social Activities

STRENGTHS:

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

FAMILY INFORMATION:

Primary Household:

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

Secondary Household: Yes No

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

Do any of the following apply to your child's living situation?

- | | | |
|--|-----|----|
| • Does your child's behavior cause significant stress in the home? | Yes | No |
| • Recent major changes or stresses in the child's family or home life? | Yes | No |
| • Significant conflict with siblings or others living in the home? | Yes | No |
| • Marital problems between parents or caregivers? | Yes | No |
| • Alcohol or drug problems in the home? | Yes | No |
| • Domestic violence in the home? | Yes | No |

PAST MEDICAL HISTORY:

Pregnancy and Birth:

- Any difficulties with pregnancy? _____
- Did mother use any of the following during pregnancy?

• Cigarettes/Vaping:	Yes	No	• Street drugs:	Yes	No
• Alcohol:	Yes	No	• Prescribed medicine(s):	Yes	No
- Where was child born? _____
- Was it a difficult delivery? Yes No

• Did your baby need oxygen?	Yes	No
• Vigorous Resuscitation?	Yes	No
• Prolonged hospitalization after birth?	Yes	No
- Birth weight _____lb _____oz
- Premature birth? Yes No How early? _____ weeks gestation

Major Illnesses:

- Seizures? Yes No Type _____ Treatment _____
- Heart Problems? Yes No Type _____ Treatment _____
- Other: _____

Current Medications: _____

Hospitalizations: Yes No (if yes, explain) _____

Surgeries: Yes No (if yes, explain) _____

Serious Injuries:

- Head injuries? Yes No How many? _____ What age(s)? _____
- Poison ingestions? Yes No Name of poison(s): _____ What age(s)? _____
- History of physical, emotional, sexual abuse? Yes No Neglect? Yes No
(If yes explain) _____

DEVELOPMENTAL HISTORY:

Did/does your child have delays in the following areas?

Big muscle development?

- Late sitting up (after 8 months)? Yes No
- Late walking (after 15 months)? Yes No

Coordination?

- Problems throwing/catching ball? Yes No
- Problems running/jumping? Yes No
- Problems riding a bicycle? Yes No

Fine motor skills?

- Problems tying shoes? Yes No
- Problems coloring in the lines? Yes No
- Problems using scissors? Yes No
- Problems with handwriting? Yes No
- Difficult to read handwriting? Yes No

Language development?

- Late single words (after 18 mo.)? Yes No
- Late phrases (after 2 years)? Yes No
- Late sentences (after 3 years)? Yes No
- Understanding language? Yes No
- Social aspects of language? Yes No

ADHD History: Yes No

When diagnosed? (age/grade) _____ Who made the diagnosis? _____

Learning Disability: Yes No

What Type(s)? Reading / Dyslexia Writing / Dysgraphia Math / Dyscalculia Auditory Processing

When diagnosed? (age/grade) _____ Who made the diagnosis? _____

Mealtime problems:

- | | | | | | |
|-------------------------|-----|----|---------------------------------------|-----|----|
| • Dietary restrictions? | Yes | No | • Feeding causes stress for parent? | Yes | No |
| • <i>Specify</i> _____ | | | • Difficulty sitting through meals? | Yes | No |
| • Picky eater? | Yes | No | • Needs distraction (e.g. TV) to eat? | Yes | No |

Elimination problems:

- | | | | | | |
|---------------------------------|-----|----|----------------------------|-----|----|
| • Late in toilet training? | Yes | No | • Accidents after trained? | Yes | No |
| • Late in staying dry at night? | Yes | No | • Constipated? | Yes | No |

Sleep problems:

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

Struggles with Routines:

- | | | | | | |
|-----------------------------------|-----|----|------------------------------------|-----|----|
| Problems leaving the house in AM? | Yes | No | Problems with bedtime? | Yes | No |
| • Needs reminders? | Yes | No | • Resists going to bed? | Yes | No |
| • Gets distracted? | Yes | No | • Electronics in bedroom? | Yes | No |
| • Late unless prodded? | Yes | No | • Electronics w/in 1hr of bedtime? | Yes | No |
| • Forgets steps of routine? | Yes | No | • Forgets steps of routine? | Yes | No |

SCHOOL:**1. Academic:**

- | | | | | | | | | |
|---|-----|----|----------------------|-------|----|----------|-----|----|
| • Is your child below grade level? | Yes | No | If yes, by how much? | _____ | | | | |
| • Does teacher raise concerns about progress? | Yes | No | | | | | | |
| • Struggles or gets extra help in: | | | | | | | | |
| Reading? | Yes | No | Math? | Yes | No | Writing? | Yes | No |

What contributes to learning difficulties?

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

2. Behavior:

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

Does your child have an IEP or 504 Plan? Yes No If yes, IEP or 504?

If yes, please list accommodations and/or pull-out services:

SOCIAL:

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

If problems with peer relationships, what behaviors get in the way of success?

INTERESTS & ACTIVITIES: _____**MEDIA USE:** _____**EXECUTIVE FUNCTION:****Focus and Distractibility:**

- | | | | | | |
|---|-----|----|---|-----|----|
| • Inattentive in non-school activities? | Yes | No | • Does your child daydream a lot? | Yes | No |
| ◦ During chores? | Yes | No | • Difficulty with multiple instruction? | Yes | No |
| ◦ Getting dressed? | Yes | No | • Distracted easily during homework? | Yes | No |
| • Problems with transitions? | Yes | No | ◦ Gets up and down? | Yes | No |
| ◦ Hard to stop current activity? | Yes | No | ◦ Needs 1:1 to stay on task? | Yes | No |
| ◦ Change in usual day/week? | Yes | No | ◦ Takes long time to finish work? | Yes | No |

Activation:

- | | | | | | |
|--------------------------------|-----|----|--|-----|----|
| • Appears unmotivated to work? | Yes | No | • Procrastinates with non-preferred tasks? | | |
| | | | ◦ Homework: | Yes | No |
| | | | ◦ Chores: | Yes | No |

Effort:

- | | | | | | |
|---|-----|----|------------------------------------|-----|----|
| • Hard to sustain effort on some tasks? | Yes | No | • Gives up easily or "shuts down"? | Yes | No |
| • Easily frustrated? | Yes | No | | | |

Memory:

- | | | | | | |
|-------------------------------|-----|----|-----------------------------------|-----|----|
| • Short-term memory problems? | Yes | No | • Doesn't learn from experience? | Yes | No |
| ◦ Loses and misplaces things? | Yes | No | • Forgets to turn in homework? | Yes | No |
| ◦ Forgets things at school? | Yes | No | • Trouble remembering schoolwork? | Yes | No |

Emotion:

- | | | | | | |
|--|-----|----|---------------------------------|-----|----|
| • Has big reactions to small triggers? | Yes | No | • Hitting or fighting? | Yes | No |
| • Has "meltdowns"? | Yes | No | • Breaking or throwing objects? | Yes | No |
| • Has anger problems? | Yes | No | • Destroying property? | Yes | No |

Activity/Impulsivity:

- | | | | | | |
|-------------------------------------|-----|----|--|-----|----|
| • Hyperactive? | Yes | No | • Makes impulsive statements? | Yes | No |
| • Fidgety or wiggly? | Yes | No | ◦ Problems interrupting? | Yes | No |
| • Does your child talk excessively? | Yes | No | ◦ Problems blurting out? | Yes | No |
| • Can't sit quietly and watch TV? | Yes | No | • You avoid restaurants with your child? | Yes | No |
| | | | • You avoid shopping with your child? | Yes | No |

Organization / Time management / Planning:

- | | | | | | |
|------------------------------------|-----|----|-----------------------------------|-----|----|
| • Cannot keep track of homework? | Yes | No | • Difficulty making an outline? | Yes | No |
| • Many missing/late assignments? | Yes | No | • Difficulty breaking into steps? | Yes | No |
| • Difficulty with school projects? | Yes | No | • Easily overwhelmed by projects? | Yes | No |

ADDITIONAL CONCERNS:

Self-esteem:

- Your child has poor self-esteem? Yes No
- Makes self-derogatory statements? Yes No

Mood:

- Child acts sad or down? Yes No
- Child acts irritable/angry often? Yes No
- Child has been withdrawn? Yes No
- Not interested in things they enjoy? Yes No
- Recent change in appetite? Yes No
- Recent change in sleep? Yes No
- Child has weeks of being super happy, energetic, more confident than usual? Yes No
- Do any of the above cause problems with family, friends, or school? 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
- Hates school? Yes No
- Has difficulty meeting new people? 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
- Has excessive fear of germs? Yes No
- Do any of the above cause problems with family, friends, or school? Yes No

Oppositional or defiant behaviors:

- Problems with obedience/compliance? Yes No
 - Argumentative? Yes No
 - Oppositional or defiant? Yes No
 - Blames others? Yes No
- Does your child lie? Yes No
 - Refuses to admit responsibility? Yes No
 - Makes up untrue stories? Yes No
- Any association with a gang? Yes No
- Does your child steal? Yes No
 - Money from home/others' toys? 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

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
- Make repetitive vocal noises? Yes No

Substance Abuse:

- Ever got in trouble for using:
 - Nicotine / Vaping? Yes No
 - Alcohol? Yes No
- Ever use marijuana? Yes No
- Other illicit drugs? Yes No
- Ever been in rehab? Yes No
 - If yes, When? For what substance?
 - _____

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

Prior evaluation(s) _____

Tutoring _____

Counseling _____

Parent Supports _____

Therapies _____

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

Other _____

Medication Details (if applicable):

- Names / dose/ dates taken: _____
- Side effects? _____
- Why stopped? _____ When stopped? _____

Discipline techniques that are helpful:

- Time-outs? Yes No • Restriction of privileges? Yes No
- Consequence system? Yes No • Nothing works? Yes No
- Reward system? Yes No • Other? _____

FAMILY HISTORY: List person affected and relationship to child.

- ADHD: Yes No _____
- Learning disability: Yes No _____
- Anxiety/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 _____
- Trouble with the law: Yes No _____

GOALS:

What do you want to see happen for your child?

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