dayspring

Parent Questionnaire

Dear Parent(s): Please complete the following questionnaire so that we may have accurate background information regarding your son or daughter. All information will be kept confidential and will not be released without your permission.

Name of Child: _____ Questionnaire completed by: _____

Relationship to Child: _____ Age: _____ Birthdate: _____ Grade: _____

Concerns:
What are the reasons for requesting services at this time?

_____
_____
_____
_____
_____
_____

What do you want to see happen?

_____
_____
_____

With regard to your child's difficulties, what patterns do you see (i.e. triggers, frequencies etc.?)

_____
_____
_____

When did your child first become a concern for you?

_____
_____

Previous Intervention:
What home interventions have you tried?

_____

What school interventions (including school evaluations) have been tried?

_____
_____

Medication:
Is your child currently on any psychiatric medication? ( ) Yes ( ) No
If yes, what medication is being prescribed? _____
Name and dose of current medication: _____
Prescribing physician: _____
Name of past medication: _____ Prescribing physician: _____

Family History:
With whom does the child live? ( ) Birth parents ( ) Adoptive parents
( ) Foster parents ( ) Other, please describe: _____

If parents are separated or divorced, date of separation/divorce:_____
Who has legal custody? _____

List all persons living in the home:
Name Relationship Age
_____
_____
_____
_____
_____

Medical/Developmental History:
Pregnancy or birth complications? ( ) Yes ( ) No
If yes, please describe:
_____
_____

Developmental Milestones: (Ages) Sitting: _____ Walking: _____Talking: _____ Toileting: _____

Please describe any current or past medical difficulties:
_____
_____
_____

Name of current physician: _____
Date of last physical exam: _____
Any actual, or suspected hearing/vision difficulties? ( ) Yes ( ) No
If yes, explain: _____

Please check if applicable:	Child	Father	Mother	Grandma	Grandpa	Brother	Sister	Other Relative
Learning Difficulties								
Attention Difficulties								
Social Difficulties								
Behavior Difficulties								
Suspected, or Actual Giftedness								
Depression or Anxiety								
Psychiatric Difficulties								
Suicide/Suicide Attempt								
Alcohol/Substance Abuse								
Criminal Activity								
Other								

School History:
List all current and past schools:

Grade (s) School Performance

_____
_____
_____
_____
_____

Current or past special education services? ( ) Yes ( ) No
If yes, please describe:

_____
_____

Please describe any other information that may be pertinent to your child's care:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Your signature: _____ Date: _____

Reviewed by: _____ Date: _____
Clinician's signature