Promoting Balance and Stability in Kids and Teens

GYROPSYCHOLOGY SERVICES, INC

PARENT QUESTIONNAIRE

IDENTIFYING INFORMATION:

Child's Name:_____ DOB:_____ Age:_____ Sex: M F Today's Date:_____

Address:_____ City:_____ State:_____ Zip_____ Phone:_____

Name of Person Completing this form:_____ Relationship to child:_____ Phone:_____

Who suggested your child be seen by a psychologist?:_____

HISTORY: Living Arrangements

This child is currently living with (please check all that apply):

_____ Biological mother, Age: _____
_____ Biological father, Age: _____
_____ Siblings (please write name, age):
_____ Adoptive parent(s), NON-RELATIVE

Does the child know he/she is adopted? No Yes

_____ Foster parent(s)
How long has the child been in foster care? Year_____Month_____
How long has the child been living in your household? Year_____Month_____

_____ Other (please specify)_____

_____ Adoptive parent(s), relative

Does the child know he/she is adopted? No Yes

The parents of this child are currently (please check one):

_____ Married to each other Year_____Month_____
_____ Divorced from each other Year_____Month_____
_____ Separated from each other Year_____Month_____
_____ Never married to each other

_____Other (please specify)_____

_____Don't know

How would you describe the current relationship between this child's parents (please check one):

_____ Friendly / Amicable
_____ Unfriendly / Conflict ridden
_____ No relationship

_____Not applicable (please specify)_____

_____ Don't know

Are there any immediate family members who do not live with your child (biological mother, biological father, or siblings)? No Yes

Please specify relationship to child:_____

Are the parent(s)/Guardian(s) of this child working outside of the home? No Yes

Please specify who & where_____

Do you have family or social support locally? No Yes
Please specify:

CHIEF CONCERN(S):
Please list the problems, questions or concerns for which you want help for your child.
1.
2.
3.
4.
5.

Did a specific event lead you to request treatment at this time? If yes, please explain:

Please describe your child's strengths:

Please describe your child's challenges:

Please write a brief history of the problems or concerns that you identified. Please begin with how old your child was when the problem(s) were first observed.

What are your goals for your child?

DEVELOPMENTAL: Pregnancy & Birth
How much did your child weigh at birth? _____pounds_____ounces

Biological father's age at birth of this child:_____Biological mother's age at birth of this child:_____

Were there any problems during the pregnancy? No Yes Please explain:

Were there any problems during labor/delivery of following birth? No Yes Please explain:

Was your child born by cesarean/c-section? No Yes If yes, circle appropriate response: planned emergency

Was your child born two or more weeks before the due date? No Yes If yes, how many weeks early was the child?_____weeks.

Other Problems? Please describe:

Were any substances or medications used by the mother during pregnancy? No Yes If yes, please specify:
_____Beer/Wine _____Alcohol _____Prescription Medications _____Cocaine _____Tobacco

_____Marijuana _____Methamphetamine (Crystal/Ice) Other:

Were any substances or medications used by the father during pregnancy? No Yes If yes, please specify:
_____Beer/Wine _____Alcohol _____Prescription Medications _____Cocaine _____Tobacco

_____Marijuana _____Methamphetamine (Crystal/Ice) Other:_____

DEVELOPMENTAL: Postnatal Period & Infancy

Were there early infancy feeding problems?	No	Yes	Please explain:_____
Was your child difficult to calm down?	No	Yes	Please explain:_____
Was your child an irregular eater?	No	Yes	Please explain:_____
Was (s)he colicky?	No	Yes	Please explain:_____
Were there early infancy sleep pattern difficulties?	No	Yes	Please explain:_____
Were there problems with the infant's alertness?	No	Yes	Please explain:_____
Did (s)he have any health problems during infancy?	No	Yes	Please explain:_____

Was the child an easy baby? Meaning, did (s)he cry a lot? Did (s)he follow a schedule fairly well?

Very Easy Easy Average Difficult Very Difficult

When she wanted something, how insistent was (s)he?

Very Pretty Average Not Very Not at all

How did the baby behave with other people?

More sociable than average Average socially Less sociable than average

How would you rate the activity level of the child as an infant/toddler?

Very Active Average Less active Not active

DEVELOPMENTAL: Milestones

At what age did (s)he sit up without help?

3-6 months 7-12 months Over 12 months Don't know

At what age did (s)he crawl?

3-6 months 7-12 months Over 12 months Don't know

At what age did (s)he walk alone without assistance?

Under 1 year 1-2 years 2-3 years Don't know

At what age did (s)he speak single words (other than "mama", "dada", "ball", etc.)?

9---13 months 14---18 months 19---24 months 25---36 months 37---48 months Don't know

At what age did (s)he string two or more words together (e.g., mama up")?

9---13 months 14---18 months 19-24 months 25-36 months 37-48 months Don't know

At what age was (s)he toilet trained (bladder control)?

Under 1 year 1-2 years 2-3 years 3-4 years Don't know

DEVELOPMENTAL: Behavioral History

Was your child highly active, restless & always into things?	No	Yes	If yes, when was this first observed?_____
Did your child frequently shift from one thing to the next?	No	Yes	If yes, when was this first observed?_____
Did they have difficulty adjusting to new situations?	No	Yes	If yes, when was this first observed?_____
Were they whiny and irritable?	No	Yes	If yes, when was this first observed?_____
Was your child bothered by sounds, touch, fabrics, etc.?	No	Yes	If yes, when was this first observed?_____
Did they have trouble with changes in daily activities? Inflexible?	No	Yes	If yes, when was this first observed?_____
Were they slow to warm up to others?	No	Yes	If yes, when was this first observed?_____
Were they sociable and affectionate?	No	Yes	If yes, when was this first observed?_____
Did your child have many temper tantrums?	No	Yes	If yes, when was this first observed?_____
Has your child ever had tics or nervous twitches?	No	Yes	If yes, when was this first observed?_____
Do you consider your child to be accident prone?	No	Yes	If yes, when was this first observed?_____

Please identify other problem behaviors that have occurred in the past:_____

DEVELOPMENTAL: Sleep History

Does your child have any problems falling asleep?	No	Yes	If yes, how often:_____	Age began?_____
Does your child have any problems staying asleep during the night?	No	Yes	If yes, how often:_____	Age began?_____
Does your child have any problems getting up in the morning?	No	Yes	If yes, how often:_____	Age began?_____
Does your child often have nightmares?	No	Yes	If yes, how often:_____	Age began?_____
Does your child have night terrors?	No	Yes	If yes, how often:_____	Age began?_____
Do they walk in their sleep?	No	Yes	If yes, how often:_____	Age began?_____

Please identify other sleep problems that have occurred in the past:_____

HISTORY: Medical

How would you describe your child's health?	Very Good	Good	Fair	Poor	Very Poor
How is his/her hearing?	Good	Fair	Poor	Don't know	
How is his/her vision?	Good	Fair	Poor	Don't know	
How is his/her gross motor functioning?	Good	Fair	Poor	Don't know	
How is his/her fine motor functioning?	Good	Fair	Poor	Don't know	
How is his/her speech articulation?	Good	Fair	Poor	Don't know	

Has (s)he had any chronic health problems (e.g., asthma, diabetes, heart condition)? No Yes If yes, please specify:_____

When was the onset of any chronic illness?

Birth	0-1 year	1-2 years	2-3 years	3-4 years	Over 4 years

Is there any suspicion of alcohol or drug abuse?	No	Yes	If yes, explain:_____
Does your child have frequent stomachaches?	No	Yes	If yes, explain:_____
Does your child have frequent headaches?	No	Yes	If yes, explain:_____
Does your child have problems with his/her weight?	No	Yes	If yes, explain:_____
Does your child have urine accidents?	No	Yes	If yes, explain:_____
Does your child have stool/bowel accidents?	No	Yes	If yes, explain:_____
Is your child constipated?	No	Yes	If yes, explain:_____
Has your child had any major health problems?	No	Yes	If yes, explain:_____
Has your child ever been hospitalized?	No	Yes	If yes, explain:_____
Has your child ever lost consciousness or had a serious head injury?	No	Yes	If yes, explain:_____
Has your child had seizures?	No	Yes	If yes, explain:_____
Has your child had any difficulties with growth?	No	Yes	If yes, explain:_____
Has your child ever been diagnosed with a genetic disorder?	No	Yes	If yes, explain:_____
Has your child ever had surgery?	No	Yes	If yes, explain:_____

HISTORY: Family Medical Problems

Does anyone in the FAMILY have any of the following:				If yes, how is this person related to this child?
Neurological Problems	No	Yes	D/K	_____
Learning or Reading difficulties	No	Yes	D/K	_____
Depression	No	Yes	D/K	_____
Bipolar Disorder/Manic Depression	No	Yes	D/K	_____
Schizophrenia	No	Yes	D/K	_____
History of physical Abuse	No	Yes	D/K	_____
History of Sexual Abuse	No	Yes	D/K	_____
Alcohol or Drug Abuse	No	Yes	D/K	_____
ADHD/ADD (attention problems)	No	Yes	D/K	_____
Tics or Tourette's disorder	No	Yes	D/K	_____
Trouble with the Law; Arrested	No	Yes	D/K	_____
Mental Retardation	No	Yes	D/K	_____
Aggressive or Violent	No	Yes	D/K	_____
Failure to Graduate from High School	No	Yes	D/K	_____
Suicide	No	Yes	D/K	_____
Anxiety Disorder/Panic Attacks	No	Yes	D/K	_____
Obsessive-Compulsive Disorder	No	Yes	D/K	_____

Seizures	No	Yes	D/K	
Autism, Asperger's Syndrome, PDD	No	Yes	D/K	
Birth Defects	No	Yes	D/K	
Hearing problems	No	Yes	D/K	
Vision problems	No	Yes	D/K	

Please list any other family health, developmental, learning or mental health problems you think may be important.

HISTORY: Child's Past/Current Treatment

Has your child ever been diagnosed with a psychological disorder? No Yes If yes, when were they diagnosed?

What was their diagnosis?

Has your child ever received psychological counseling for any problems? No Yes If yes, please describe:

Is your child currently taking any medication? No Yes

If yes, what medications are they currently taking:

Are there any professional (such as doctors, psychiatrists, social workers, occupational therapists, speech therapists, physical therapists, or alternative treatments) currently involved in this child's care? Please list them and their role in your child's care.

HISTORY: Social

Do you have any specific concerns about your child's social skills or their development of age-appropriate social skills?

How does your child get along with his/her siblings?

Doesn't have any Better than average Average Worse than average

How easily does the child make friends?

Easier than average Average Worse than average Don't know

On average, how long does your child keep friendships?

Less than 6 months 6 months --- 1 year More than 1 year Don't know

How many friends does your child have? 1 2 – 3 4 – 5 6 or more

Is your child involved in any social groups (e.g., church youth group) or recreational/educational activities (e.g., soccer, ballet, piano)? No Yes

HISTORY: Environmental History

Have there ever been any major changes or stressors in your child's life (e.g., martial problems, a move, change of school, birth of a brother or sister, a death of a pet)? No Yes

If yes, please specify and include how old your child was at the time:

Is this stress still occurring? No Yes

Has there been a serious illness or death in a parent or close family member of your child? No Yes

If yes, please specify and include how old your child was at the time:_____

Has your child experienced or seen any traumatic events (e.g., domestic violence, physical or sexual abuse)? No Yes

If yes, please specify and include how old your child was at the time:_____

Is this trauma still occurring? No Yes

Are there any major changes or stressors expected in the future? No Yes

If Yes, please specify:_____

HISTORY: Military

Are you or another parent/guardian of your child currently in the military? No Yes What branch:_____

Are any of the child's parent(s)/guardian(s) active duty military? If yes, who Mother Father Both Other:_____

Are they deployed or deployable? No Yes Please specify:_____

When are you/they scheduled to PCS/Move? Date:_____

Is your child or other members of this family in the Exceptional Family Member Program (EFMP)? No Yes

HISTORY: School Information

Name of school:_____ Length of time at present school:_____ Grade:_____

School district:_____ Primary teacher's name:_____ School Phone:_____

Please describe your child's strongest areas in school:

Please describe your child's greatest challenges in school:

HISTORY: School Intervention(s):

Has your child been in an early intervention program or special daycare/preschool? No Yes

Has your child had speech, occupational or physical therapy? No Yes

Has your child ever attended summer school? No Yes

If yes, what grade(s):_____ Subject(s):_____

Has your child ever repeated a grade? No Yes

If yes, what grade(s):_____

Has the school ever discussed your child repeating a grade with you? No Yes

If yes, please specify:_____

Is there a possibility that the current grade of subjects will need repeating? No Yes

If yes, please specify:_____

Has your child ever received special education services (e.g., 504 plan or IEP)? No Yes

If yes, please specify:_____

Is your child currently receiving any special education services? No Yes

If yes, please specify:_____

Have any disciplinary actions been taken (detentions, suspensions, or expulsions)? No Yes

If yes, please specify:_____

Does your child need any special medical assistance? No Yes

If yes, please specify:_____

HISTORY: School Problems

Please identify your primary concerns with your child's performance at school if any:_____

For each of the following grades your child has completed, were any problems reported?

			Academic	Behavior
No	Yes	Preschool		
No	Yes	Kindergarten & 1st grade		
No	Yes	2nd & 3rd grade		
No	Yes	4th & 5th grade		
No	Yes	6th through 8th grade		
No	Yes	High School		

CURRENT: School Performance Please circle the appropriate number (1= Above Average; 5=Problematic)

Classroom assignment completion	1	2	3	4	5	Science	1	2	3	4	5
Homework completion	1	2	3	4	5	Written expression	1	2	3	4	5
Getting homework to and from school	1	2	3	4	5	Handwriting	1	2	3	4	5
Organizational skills	1	2	3	4	5	Social Studies/History	1	2	3	4	5
Reading	1	2	3	4	5	Art	1	2	3	4	5
Spelling	1	2	3	4	5	Other:_____	1	2	3	4	5
Mathematics	1	2	3	4	5						

What are your child's current grades? _____

Is there any additional information that you feel would be helpful in understanding your child?