

**CHRISTIAN COUNSELING ASSOCIATES, INC.**

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**PARENTS' QUESTIONNAIRE:  
HISTORY FORM**

Please bring this completed form with you at the time of your next appointment  
Please bring copies of relevant records (for example, recent report cards, standardized test scores, special education test reports, IEPs, etc.) and any previous psychological or psychiatric reports.

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's School: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Special Education Placement:**

Has your child been placed in a special education program?  No  Yes

If yes, hours of service per day: \_\_\_\_\_ Type of class: \_\_\_\_\_

What grade did services begin? \_\_\_\_\_ What grade did services end? \_\_\_\_\_

**Previous Educational Diagnosis:**

Communication Disorder \_\_\_\_\_ Mental Retardation \_\_\_\_\_

Autism/Pervasive Developmental Disorder: \_\_\_\_\_ Other Health Impairment: \_\_\_\_\_

Attention-Deficit/Hyperactivity Disorder: \_\_\_\_\_ Emotional Disturbance: \_\_\_\_\_

Learning Disability: \_\_\_\_\_ Reading: \_\_\_\_\_ Math: \_\_\_\_\_ Writing: \_\_\_\_\_

**Source of Referral:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax No.: \_\_\_\_\_

Briefly state the main problems of your child and when the problems began:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Parent's Questionnaire

Child's Name: \_\_\_\_\_

**PREGNANCY:**Was the pregnancy planned?  No  YesUnder Doctor's Care?  No  Yes

Complications (Specify trimester, duration): \_\_\_\_\_

Excessive vomiting \_\_\_\_\_

Hospitalization required \_\_\_\_\_

Specify weight loss, if any \_\_\_\_\_

Excessive staining/blood loss: \_\_\_\_\_ Time of gestation: \_\_\_\_\_

Threatened miscarriage: \_\_\_\_\_ Time of gestation: \_\_\_\_\_

Treatment if known: \_\_\_\_\_

Premature rupture of membranes (&gt; 24 hours): \_\_\_\_\_

Infection(s): \_\_\_\_\_ (specify) \_\_\_\_\_

Toxemia: \_\_\_\_\_ Operation(s): \_\_\_\_\_ (specify) \_\_\_\_\_

Exposure to toxic or industrial chemicals: \_\_\_\_\_

Other illness(es) or injury (specify): \_\_\_\_\_

Unusual weight gain:  No  YesSmoking during pregnancy:  No  Yes Cigarettes per day: \_\_\_\_\_

Alcoholic consumption during pregnancy: \_\_\_\_\_ Describe if beyond an occasional drink: \_\_\_\_\_

Other drugs used: \_\_\_\_\_

Medications taken during pregnancy (include over the counter drugs):

Prescription:  No  Yes

Type \_\_\_\_\_ Frequency \_\_\_\_\_

X-ray studies during pregnancy (include dental, note if shield was used):

Duration of pregnancy (weeks): \_\_\_\_\_

**DELIVERY:**

Type of labor: Spontaneous \_\_\_\_\_ Augmented with Pitocin \_\_\_\_\_

Induced (specify pitocin or rupture of membranes) \_\_\_\_\_

Duration (hours) \_\_\_\_\_ Type of delivery: normal \_\_\_\_\_ breech \_\_\_\_\_

Forceps used:  No  Yes

Caesarean \_\_\_\_\_ If C-Section, note indications: \_\_\_\_\_

Medications for labor/delivery \_\_\_\_\_

Analgesia \_\_\_\_\_ Anesthesia \_\_\_\_\_

Complications: Cord around neck \_\_\_\_\_ Hemorrhage \_\_\_\_\_

Infant injured during delivery \_\_\_\_\_ Other \_\_\_\_\_

Birth weight \_\_\_\_\_ lb, \_\_\_\_\_ oz APGAR Scores/ \_\_\_\_\_ Fetal Distress \_\_\_\_\_

Need for resuscitation \_\_\_\_\_ If so, how? \_\_\_\_\_

**POST DELIVERY PERIOD:**

Jaundice \_\_\_\_\_ If yes: How high was bilirubin, if known \_\_\_\_\_

How treated: Lights \_\_\_\_\_ Transfusion \_\_\_\_\_ Phenobarbital \_\_\_\_\_

Etiology, if known \_\_\_\_\_

Respiration (turned blue) \_\_\_\_\_ supplemental oxygen \_\_\_\_\_

Infection (specify) \_\_\_\_\_

Seizures \_\_\_\_\_ IVs \_\_\_\_\_ Birth anomalies \_\_\_\_\_ Other \_\_\_\_\_

Number of days infant was in the hospital after delivery \_\_\_\_\_

Number of days mother was in the hospital after delivery \_\_\_\_\_

## Parent's Questionnaire

Child's Name: \_\_\_\_\_

**INFANCY-TODDLER PERIOD:**

Were any of the following present – to a significant degree – during the first few years of life?

If so, describe:

Did not enjoy cuddling \_\_\_\_\_

Was not calmed down by being held or stroked \_\_\_\_\_

Colic \_\_\_\_\_ Duration \_\_\_\_\_

Time of day \_\_\_\_\_ Excessive restlessness \_\_\_\_\_

Diminished sleep \_\_\_\_\_ Frequent head banging \_\_\_\_\_

Constantly into everything \_\_\_\_\_

Excessive number of accidents compared to other children \_\_\_\_\_

Unusual behavior or development during the years 1-5 \_\_\_\_\_

How fed \_\_\_\_\_ Weight gain \_\_\_\_\_

Feeding problems \_\_\_\_\_

Disposition \_\_\_\_\_

Was your baby "floppy" or "stiff" \_\_\_\_\_

**DEVELOPMENTAL MILESTONES:**

If you can recall, record the age (month/year) at which your child reached the following developmental milestones. If you cannot recall, check item at right.

	Age	<b><u>I cannot recall exactly, but it occurred about:</u></b>		
		<u>Early</u>	<u>Normal</u>	<u>Late</u>
Smiled	_____	_____	_____	_____
Sat without support	_____	_____	_____	_____
Crawled	_____	_____	_____	_____
Turned front to back	_____	_____	_____	_____
Turned back to front	_____	_____	_____	_____
Stood without support	_____	_____	_____	_____
Walked without assistance	_____	_____	_____	_____
Spoke first words	_____	_____	_____	_____
Said phrases	_____	_____	_____	_____
Bladder trained, day	_____	_____	_____	_____
Bladder trained, night	_____	_____	_____	_____
Bowel trained, day	_____	_____	_____	_____
Rode tricycle	_____	_____	_____	_____
Rode bicycle (w/o training wheels)	_____	_____	_____	_____
Buttoned clothing	_____	_____	_____	_____
Tied shoelaces	_____	_____	_____	_____
Named colors	_____	_____	_____	_____
Said alphabet in order	_____	_____	_____	_____
Began to read	_____	_____	_____	_____

Did bed-wetting occur after toilet training?  No  Yes If yes, what age \_\_\_\_\_Did soiling occur after toilet training?  No  Yes If yes, what age \_\_\_\_\_Was there a medical reason for wetting or soiling?  No  Yes If yes, describe: \_\_\_\_\_

Parent's Questionnaire

Child's Name: \_\_\_\_\_

**MEDICAL HISTORY:**

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases (describe any complications) \_\_\_\_\_

Cuts and stitches \_\_\_\_\_ How many times \_\_\_\_\_

Broken bones \_\_\_\_\_ How many times \_\_\_\_\_

Operations \_\_\_\_\_

Hospitalizations for illness \_\_\_\_\_

Head injuries \_\_\_\_\_

Convulsions \_\_\_\_\_ with fever \_\_\_\_\_ without fever \_\_\_\_\_

Coma \_\_\_\_\_

Persistent high fevers \_\_\_\_\_

Eye problems \_\_\_\_\_ Vision problems \_\_\_\_\_

Ear problems \_\_\_\_\_ Average # of ear infections per year \_\_\_\_\_ Ear tubes placed \_\_\_\_\_

Tonsils out \_\_\_\_\_ Adenoids out \_\_\_\_\_ Poisoning \_\_\_\_\_

Sleep problems \_\_\_\_\_ Eating problems \_\_\_\_\_

Eating disorder \_\_\_\_\_ Physical abuse \_\_\_\_\_

Sexual abuse \_\_\_\_\_

Unclear speech \_\_\_\_\_

Overweight \_\_\_\_\_

**PRESENT MEDICAL STATUS:**

Date of last medical examination: \_\_\_\_\_ Results: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Present illnesses for which the child is being treated: \_\_\_\_\_

Hearing and Vision

Has your child been evaluated for:

Hearing  No  Yes If yes, date \_\_\_\_\_ Results \_\_\_\_\_

Vision  No  Yes If yes, date: \_\_\_\_\_ Results \_\_\_\_\_

**Medication History:**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

Reason prescribed: \_\_\_\_\_

Child's Response: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

Reason prescribed: \_\_\_\_\_

Child's Response: \_\_\_\_\_

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

## Parent's Questionnaire

Child's Name: \_\_\_\_\_

**COORDINATION:**

Rate your child on the following skills:

	<u>Good</u>	<u>Average</u>	<u>Poor</u>
Walking	_____	_____	_____
Running	_____	_____	_____
Skipping	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Kicking	_____	_____	_____
Shoelace tying	_____	_____	_____
Buttoning	_____	_____	_____
Writing	_____	_____	_____
Athletic abilities	_____	_____	_____
Bike riding	_____	_____	_____

Which hand does this child use for writing or drawing?  Right  LeftEating?  Right  LeftThrowing?  Right  Left**COMPREHENSION AND UNDERSTANDING:**

Do you consider your child to understand directions and situations as well as other children his or her age? If not, why not? \_\_\_\_\_

How would you rate your child's overall level of intelligence compared to other children?

Below average \_\_\_\_\_ Above average \_\_\_\_\_ Average \_\_\_\_\_

What is the primary language spoken at home: \_\_\_\_\_ Other languages your child speaks or hears at home: \_\_\_\_\_

**SCHOOL:**Rate your child's school experiences related to academic learning(grades):

	Good	Average	Poor
Nursery school	_____	_____	_____
Kindergarten	_____	_____	_____
Current grade	_____	_____	_____

Did your child attend preschool?  No  Yes

At what age did your child enter Kindergarten \_\_\_\_\_ To the best of your knowledge, at what grade level is your child functioning: Reading \_\_\_\_\_ Spelling \_\_\_\_\_ Arithmetic \_\_\_\_\_

Has your child ever had to repeat a grade? \_\_\_\_\_ If so, when? \_\_\_\_\_

Has your child skipped a grade? \_\_\_\_\_ If so, when \_\_\_\_\_

Present class placement:

Regular class \_\_\_\_\_ Special class \_\_\_\_\_ (if so, specify) \_\_\_\_\_

Kinds of special counseling or remedial work your child has received: \_\_\_\_\_

Describe briefly any academic school problems \_\_\_\_\_

Describe your child's academic strengths at school \_\_\_\_\_

Has your child ever been tested for special education?  No  Yes

If yes, previous testing results (if known) \_\_\_\_\_

Results of standardized testing (if known) \_\_\_\_\_

Current GPA \_\_\_\_\_ What level of school do you expect your child to complete?

High School  College  Technical/Vocational school  
 Graduate School (e.g. Law, Medical, or other advanced degree).

Schools Attended:

Name of School:	Grades Attended:	Reason Changed School
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rate your child's school experiences related to behavior:

	Good	Average	Poor
Nursery school	_____	_____	_____
Kindergarten	_____	_____	_____
Current grade	_____	_____	_____

Does your child's teacher describe any of the following as significant classroom problems:

Does not sit still in his or her seat \_\_\_\_\_

Frequently gets up and walks around the classroom \_\_\_\_\_

Shouts out. Does not wait to be called on \_\_\_\_\_

Will not wait his or her turn \_\_\_\_\_

Does not cooperate well in group activities \_\_\_\_\_

Typically does better in a one to one relationship \_\_\_\_\_

Does not respect the rights of others \_\_\_\_\_

Does not pay attention during storytelling or show and tell \_\_\_\_\_

Describe briefly any other classroom behavioral problems \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child like school?  No  Yes

Is your child absent frequently?  No  Yes If yes, how often? \_\_\_\_\_

**PEER RELATIONSHIPS:**

Does your child fight frequently with peers?  No  Yes

Does your child make friends easily?  No  Yes

Does your child play with children primarily his or her own age? \_\_\_\_\_

younger? \_\_\_\_\_ older? \_\_\_\_\_ Prefers to play alone?  No  Yes

Describe briefly any problems your child may have with peers: (e.g.: fights, cheats, excessively shy) \_\_\_\_\_

\_\_\_\_\_

Describe briefly any strengths your child may have with peers: (e.g. initiates play, peacemaker)

\_\_\_\_\_

Parent's Questionnaire

Child's Name: \_\_\_\_\_

What role does the child take in peer games? (leader, aggressor, boss, follower, etc.)

\_\_\_\_\_

**HOME BEHAVIOR:**

Describe briefly the positive behaviors your child shows at home: \_\_\_\_\_

\_\_\_\_\_

Describe what you find most difficult about raising your child: \_\_\_\_\_

\_\_\_\_\_

Many children exhibit, to some degree, some of the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children at his or her own age.

Hyperactivity (high activity level) \_\_\_\_\_

Poor attention span \_\_\_\_\_

Impulsivity (poor self-control) \_\_\_\_\_

Temper outbursts \_\_\_\_\_

Low frustration threshold \_\_\_\_\_

Overreacts to problems \_\_\_\_\_

Seems uncomfortable meeting new people \_\_\_\_\_

Seems unhappy most of the time \_\_\_\_\_

Sloppy table manners \_\_\_\_\_

Interrupts frequently \_\_\_\_\_

Doesn't listen \_\_\_\_\_

Sudden outbursts of physical abuse of other children \_\_\_\_\_

Acts like he or she is driven by a motor \_\_\_\_\_

Wears out shoes more frequently than other siblings \_\_\_\_\_

Heedless of danger \_\_\_\_\_

Excessive number of accidents \_\_\_\_\_

Doesn't learn from experience \_\_\_\_\_

Poor memory \_\_\_\_\_

More active than siblings \_\_\_\_\_

A "different child" \_\_\_\_\_

Grinds teeth \_\_\_\_\_ Distractible \_\_\_\_\_

Tantrums \_\_\_\_\_ Truancy \_\_\_\_\_

Wandering/Running away \_\_\_\_\_

Fire starting \_\_\_\_\_ Match play \_\_\_\_\_

Pica (eats non-food) \_\_\_\_\_

Wetting \_\_\_\_\_ Fecal soiling \_\_\_\_\_

Stealing \_\_\_\_\_ Destructive \_\_\_\_\_

Lying \_\_\_\_\_ Cruelty to animals \_\_\_\_\_

Sleeping problems \_\_\_\_\_

Rocking \_\_\_\_\_ Thumb sucking \_\_\_\_\_

Perseverative behavior \_\_\_\_\_ Self-injury \_\_\_\_\_

Talks about suicide \_\_\_\_\_

Has fears \_\_\_\_\_ If yes, describe \_\_\_\_\_

Types of discipline you use with your child and how he or she responds:

Types of disciplined usedChild's response

Parent's Questionnaire

Child's Name: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do the caregivers agree on how to discipline?  No  Yes

**INTERESTS AND ACCOMPLISHMENTS:**

What are your child's main hobbies and interests? \_\_\_\_\_

What are your child's areas of greatest accomplishment? \_\_\_\_\_

What sports does your child enjoy? \_\_\_\_\_

What does your child enjoy doing the most? \_\_\_\_\_

What does your child dislike doing the most? \_\_\_\_\_

Has your child's interest in participating in activities gone down recently?  No  Yes

If yes, describe \_\_\_\_\_

**FAMILY HISTORY:**

Are child's parents related in any way other than by marriage? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, how? \_\_\_\_\_

Family Residence

Apartment  Single Home  Other Time at current address? \_\_\_\_\_

**Family History--Mother**

Age \_\_\_\_\_ Age at time of pregnancy with patient \_\_\_\_\_

Occupation \_\_\_\_\_

School: Highest grade completed \_\_\_\_\_

Learning problems?  No  Yes If yes, describe \_\_\_\_\_

Behavior problems?  No  Yes If yes, please describe \_\_\_\_\_

Medical problems \_\_\_\_\_

Reproductive history:

Number of previous pregnancies \_\_\_\_\_

Number of live births \_\_\_\_\_

Number of spontaneous abortions \_\_\_\_\_

Number of therapeutic abortions \_\_\_\_\_

Have any of your blood relatives experienced problems in learning or development?  No  Yes

If so, describe \_\_\_\_\_

**Family History--Father**

Parent's Questionnaire

Child's Name: \_\_\_\_\_

Age \_\_\_\_\_ Age at time of pregnancy with patient \_\_\_\_\_

Occupation \_\_\_\_\_

School: Highest grade completed \_\_\_\_\_

Learning problems?  No  Yes If yes, describe \_\_\_\_\_

Behavior problems?  No  Yes If yes, please describe \_\_\_\_\_

Medical problems \_\_\_\_\_

Have any of your blood relatives experienced problems in learning

or development?  No  Yes

If so, describe \_\_\_\_\_

Does this child have any other parent(s) or step parent(s)?  No  Yes

If yes, please provide the following.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home Phone \_\_\_\_\_ Address \_\_\_\_\_

**SIBLINGS**

	<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Medical, social, or school problems</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

How does your child get along with brother(s) and sister(s)? \_\_\_\_\_

**NAMES AND ADDRESSES OF ANY OTHER PROFESSIONALS CONSULTED**

(including family doctor)

	<u>Name</u>	<u>Address</u>	<u>Phone</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

What are your expectations for your child's assessment, treatment, and ongoing care?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER EXTENDED FAMILY MEDICAL HISTORY:**

	<u>Difficulty</u>	<u>Who</u>	<u>Relationship</u>
_____	Seizures _____	_____	_____
_____	Mental Retardation _____	_____	_____

Difficulty Who Relationship

Parent's Questionnaire

Child's Name: \_\_\_\_\_

- \_\_\_\_\_ Attention Deficit Disorder \_\_\_\_\_
- \_\_\_\_\_ Communication Disorder/Autism \_\_\_\_\_
- \_\_\_\_\_ Depression \_\_\_\_\_
- \_\_\_\_\_ Schizophrenia \_\_\_\_\_
- \_\_\_\_\_ Drug Abuse \_\_\_\_\_
- \_\_\_\_\_ Alcoholism \_\_\_\_\_
- \_\_\_\_\_ Thyroid Problems \_\_\_\_\_
- \_\_\_\_\_ Genetic Metabolic Disorders \_\_\_\_\_
- \_\_\_\_\_ Anxiety \_\_\_\_\_

**SUBSTANCE ABUSE:**

Do you have any reason to suspect substance use or abuse by your child?     No     Yes  
 Have you ever felt your child ought to cut down on his/her drinking or drug use? \_\_\_\_\_  
 Has your child ever been annoyed by someone criticizing his/her drinking or drug use? \_\_\_\_\_  
 Has your child ever felt bad or guilty about drinking or drug use? \_\_\_\_\_  
 Has your child ever had a drink or used drugs first thing in the morning to steady his/her nerves or get rid of a hangover? \_\_\_\_\_

**PRESENT PLACEMENT OF CHILD:**

(Please check in appropriate bracket)

	Adult with whom child is living.	Non-residential adults involved with child.
Natural Mother	( )	( )
Natural Father	( )	( )
Stepmother	( )	( )
Stepfather	( )	( )
Adoptive Mother	( )	( )
Adoptive Father	( )	( )
Foster Mother	( )	( )
Foster Father	( )	( )
Other (specify) _____	( )	( )

Has the child ever experienced parent separation, divorce, or death? \_\_\_\_\_  
 If so, child's age at time(s) of divorce(s) or death. \_\_\_\_\_, what year? \_\_\_\_\_  
 Please describe the circumstances. \_\_\_\_\_  
 \_\_\_\_\_

If parents, are separated or divorced, who has legal custody? \_\_\_\_\_  
 How often does the other parent see the child? \_\_\_\_\_  
 Number of times child has moved \_\_\_\_\_

**PARENTS**

**Mother** \_\_\_\_\_ **Stepmother?**     No     Yes  
**Employer** \_\_\_\_\_ **Business phone** \_\_\_\_\_  
**Business name** \_\_\_\_\_  
**Business address** \_\_\_\_\_  
 How long with present employer? \_\_\_\_\_

## Parent's Questionnaire

Child's Name: \_\_\_\_\_

**Father** \_\_\_\_\_ Stepfather ?  No  Yes

Employer \_\_\_\_\_ Business phone \_\_\_\_\_

Business name \_\_\_\_\_

Business address \_\_\_\_\_

How long with present employer? \_\_\_\_\_

**ADDITIONAL REMARKS:**

Please use the bottom of this page to write any additional remarks you wish to make regarding your child's difficulties.

Form completed by: Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Date: \_\_\_\_\_