



A for-profit

organization

**Kuiper Neurobehavioral Clinic
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PARENT QUESTIONNAIRE

Date: _____

Name of Person Completing Questionnaire (If not parent, please state your relationship to the client) _____

Name of Client: _____ Age: _____ DOB: _____ Gender: _____
 City/State/Zip: _____
 Phone: (home) _____ (other) _____
 School: _____ Grade: _____

Parent(s) or Guardian(s) of minor:

Name: _____ Relationship to child: _____
 Address: (if different from above) _____
 City/State/Zip _____
 Phone: (home) _____ (work) _____ (cell) _____

Name: _____ Relationship to child: _____
 Address: (if different from above) _____
 City/State/Zip _____
 Phone: (home) _____ (work) _____ (cell) _____

Physician/other health care professional (psychologist, psychiatrist, therapist, etc):

Name: _____ Phone _____
 Diagnosis: _____
 Current Medications: _____

What benefit do you hope your child gains from therapy?

Developmental History - Please indicate your child's history in relation to following:

Prenatal stress or injury	Yes	No	Details
Prenatal drug/alcohol exposure			
Birth trauma (forceps, breech, etc.)			
Anesthesia, pain medications			
Anoxia (oxygen deprivation @ birth)			
Prenatal stress or injury (cont'd)	Yes	No	Details
Premature/late delivery			
Medical problems after birth			
Other problems			

Birth weight _____

Other _____

Family History

Child currently lives with _____

If your child is adopted, please indicate age of adoption _____

If you have legal guardianship, how long has the child been in your care _____

Please indicate child's age when legal guardianship was officially granted or if it is still pending _____

Growth and development

Completion of Developmental Milestones (e.g., walking, talking, toilet trained, etc.):

Within Normal Limits: Yes _____ No _____

(if no, please explain and include age at which milestones were achieved)

Physical Traumas**

	Yes	No	Describe (additional space provided below)
Head injury (even minor falls, etc.)			
Accidents (list all)			
High fever			
Seizures			
Serious illness			
Surgery			
CNS infection (e.g. meningitis)			
Drug overdose/poisoning			
Recreational drug use			
Other			

Client Name: _____

**This includes accidents/injuries/illnesses that did not result in a hospital visit

Psychological Stress/Life Changes

	Yes	No	Dates
Divorce/Remarriage			
Physical abuse			
Sexual abuse/assault			
Witness of violence at home			
Move/relocation			
School Change			
Chronic illness of family members			

Treatment History

Medical Treatment

Procedure	For Condition	Description	Dates

Psychological Services

Therapy	For Condition	Therapist	Dates

Other Therapy Services (e.g., Speech and Language Therapy, Occupational Therapy, Physical Therapy)

Therapy	For Condition	Therapist	Dates

Psychiatric Hospitalization

Presenting problem	Name of hospital and length of stay	Medication prescribed (yes/no)	Dates

Medications (past and present)

Name of medication	Dosage	Side effects (yes/no)	Dates of use

Academic History

Current school _____

Number of schools attended _____

Names of previous schools attended _____

Is your child receiving Special Education services _____

Has your child ever been retained/required to repeat a grade _____

What are your child's academic strengths and weaknesses _____

Has your child ever been suspended? If so, for what reason(s) _____

Symptom Checklist

Please indicate if the client and/or family members (e.g., parents, grandparents, siblings, aunts, uncles) currently experience or have a history of any of the following symptoms:

Symptoms	√ if client	√ if family	√ if current
Feeling tense			
Depressed			
Always on the go			
School/Work problem			
Impulsivity			
Hyperactivity			
Attention problems			
Behavior problems			
Vocal or motor tics			
Sleep problems			
Legal trouble			
Headaches			
Feeling lonely			
Frequent illness			
Repetitive thoughts			
Repetitive behavior			
Shy with people			
Allergies			

Client Name: _____

Symptoms	√ if client	√ if family	√ if current
Asthma			
Seizures			
Chronic pain			
Food sensitivity			
Head injury			
Memory problems			
Can't make decisions			
Temper tantrums			
Rages			
Verbal aggression			
Physical aggression			
Stubbornness			
Bowel disturbances			
Chronic fatigue			
Dizziness			
Fainting spells			
Stomach trouble			
Poor appetite			
Picky eater			
Nightmares			
Feeling panicky			
Alcohol/Drug problems			
Suicidal ideas			
Physical/Sexual abuse			
Learning problems			
Communication or language problems			