Parents Questionnaire

Date: _____

Child's name: _____

Birthdate: _____ Place of Birth: _____
City State

Home Address: _____

_____
City State Zip Code

Biologic Father: _____ Birthdate: _____
Occupation: _____ Religion: _____
Ethnic Background: _____ Years of Schooling: _____
Health: _____

Biologic Mother: _____ Birthdate: _____
Ethnic Background: _____ Years of Schooling: _____
Health: _____

What is it about your child that concerns you? _____

_____

_____

When was it first noticed? _____

What have you been told with regard to this concern? _____

_____

_____

What things do you presently NOT understand about your child? _____

_____

_____

_____

How do you think that we might be able to help you? _____

_____

_____

Pregnancy

Questions in this and the following section refer to the pregnancy of the child for which you to seek assistance.

How old were you when you became pregnant? _____ Did you have problems getting pregnant?_____

Was this a planned pregnancy? _____ Feelings about being pregnant: _____

_____

During which month did you start prenatal care? _____Where? _____

Weight before pregnancy: _____ Weight gain: _____

Any weight loss in any part of the pregnancy? _____ If so, when?_____

Medicines taken and when (include all medication such as vitamins, birth control pills, etc., including aspirin if taken frequently) _____

_____

Did you smoke during pregnancy?_____ If so, when during pregnancy?_____

How many cigarettes per day? _____ Did you consume alcohol during pregnancy?_____

Number of alcoholic drinks per week: _____ if so, when? _____

Any narcotics or drug use prior to or during this pregnancy? _____

Any illnesses? _____

If so when? _____

Did you take any antibiotics during pregnancy?_____

Did you have any fever during pregnancy? _____1st 3 mos _____ 2nd 3 mos _____3rd 3 mos

For how long did it persist? _____ hours, or _____ days

X-rays during or shortly before pregnancy? _____Vaginal bleeding? _____

High blood pressure? _____Much morning sickness? _____

Much swelling? _____

Bleeding or spotting during pregnancy? _____ If so, when? _____

Hospitalizations? _____

Operations? _____

Accidents? _____

Unusual worries? _____

Special diet? _____

When did you first feel the baby move? _____

How were the baby's movements during pregnancy?

_____ Stronger than expected _____Weaker than expected _____ About the same as expected

Birth History

Questions in this section refer to the pregnancy of the child for which you to seek assistance.

Was the baby on time, early or late? _____

Was any stimulation of labor used? _____ Type: _____

Length of labor in hours: _____

Length of time before delivery that "bag of water" broke? _____

Type of anesthesia or pain relief:

Sedative _____ Spinal _____

Epidural _____ General _____

Other _____

Where you awake when the baby was born? _____

Type of delivery:

Natural (vaginal) _____ Breech _____ Forceps _____

Cesarean Section _____ Planned _____ Not planned _____ Emergency _____

Mother's Blood Group (A, B, AB, O): _____ Mother's Rh factor (neg or pos): _____

Father's Blood Group (A,B, AB, O): _____ Father's Rh factor (neg or pos): _____

Baby's birth weight: _____ Birth Length: _____ Head circumference: _____

Infant's conditions:

Breathed immediately _____ Cried immediately _____

Required oxygen _____ Length of stay in nursery _____

Seizures _____ Apgar score: 1minute _____ 5 minute _____

Problems during the first week (i.e., incubator, hyaline membrane disease, oxygen therapy, prematurity, yellow skin [jaundice], feeding difficulties, bleeding tendency, infection, etc.) _____

_____

Medicine given during hospital stay: _____

Was this child: Breast fed _____ Bottle fed _____ Both _____ Did the child eat well? _____

Sleep patterns _____

_____

Development

We would like to have information about some of the developmental milestones of your child. Indicate the age in months when your child first did each of the following: (indicate that the child has not yet done it by writing 'no'. If you do not remember the exact time, write 'NR'.) Please be as specific as possible in pinpointing the age.

Head held erect: _____ Sat up without help: _____

Rolled over front to back: _____ Crawled: _____

Rolled back to front: _____ Pulled up to stand: _____

Stood alone: _____ Smiled in response to your smile: _____

Walked holding on to furniture: _____ Fed self handfood: _____

Walked alone (10-15 steps): _____ Drank from cup: _____

Ran without falling often: _____ Played pat-a-cake. _____
peek-a-boo or waved bye bye

Walked up steps holding on: _____ Recognized parents: _____

Showed fear of strangers: _____ Said "ma-ma" or "da-da": _____

Used word: _____ Used spoon without spilling much: _____
(other than "ma-ma" or "da-da" with meaning)

Said three single words: _____ Combined different words: _____

Used sentences: _____ Put on clothes: _____

Repeated words others said: _____ Able to tie shoes _____ years

Rode tricycle: _____

Is your child right or left handed? _____

When did you first notice a hand preference? _____

Health Problems

If your child has had any of the problems noted in the charts below, please put an "X" in the column under the age at which the problem(s) occurred. If a problem occurred over a long period, or over and over again, please check in the columns for ***each age*** during which the problem existed. If your child has never had the problem, put an "X" in the "Never" column.

	Health Problems	NEVER	0-3 mos	4-6 mos	7-12 mos	13-18 mos	19-24 mos	2-3 yrs	3-4 yrs	4-5 yrs	5-7 yrs	since 7 yrs
1	Ear Infection(s)											
2	Rashes or skin problems											
3	Meningitis											
4	Seizures (convulsions) or spells											
5	High fevers (over 104º F or 40º C)											
6	Slow weight gain											
7	Trouble with hearing											
8	Trouble with eyes or vision											
9	Pneumonia											
10	Asthma											
11	Bowel problems											
12	Hospitalization(s)											
13	Surgery (operations)											
14	Serious injury (injuries)											
15	Food allergies											
16	Other allergies											
17	Anemia (low blood count)											
18	Lead poisoning											
19	Other poisonings or overdose											
20	Heart problems											
21	Kidney or urinary problems											
22	Other important illnesses (specify):											
	a.											
	b.											
23	Medications used over a long period (specify):											
	a.											
	b.											

Functional Problems

If your child has had any of the problems noted in the charts below, please put an "X" in the column under the age at which the problem(s) occurred. If a problem occurred over a long period, or over and over again, please check in the columns for ***each age*** during which the problem existed. If your child has never had the problem, put an "X" in the "Never" column.

	Health Problems	NEVER	0-3 mos	4-6 mos	7-12 mos	13-18 mos	19-24 mos	2-3 yrs	3-4 yrs	4-5 yrs	5-7 yrs	since 7 yrs
1	Feeding difficulty											
2	Poor appetite											
3	Very unpredictable behavior											
4	Extreme hunger											
5	Colic											
6	Constipation											
7	Stomach aches											
8	Trouble falling asleep											
9	Trouble staying asleep											
10	Very unpredictable length of sleep											
11	Very heavy sleeper											
12	Overactivity											
13	Head banging											
14	Rocking in bed											
15	Temper tantrums											
16	Self-destructive behavior											
17	Difficulty in being comforted or consoled											
18	Stiffness or rigidity											
19	Crying often or easily											
20	Shyness with strangers											
21	Bashfulness with new children											
22	Irritability											
23	Extreme reaction to noise or sudden movement											
24	Difficulty in keeping to a schedule											
25	Trouble getting satisfied											
26	Desire to be held too often											
27	Failure to be affectionate towards parents											
28	Unwillingness to go along with change in daily routine											
29	Tendency to make odd sounds/ grunts/snorts											
30	Tendency to twitch or jerk arm(s) or head often											

Schools

Questions in this section refer to the child whose concerns has caused you to seek assistance.

Has this child ever been in preschool or day care?_____

If yes, list preschools or day cares child has attended:

Name of Day Care or School	Age of Attendance	Problems

List of elementary schools that child has attended:

Name of School	Grade(s)	Problems

Has your child ever been held back in school? _____

Has your child ever been in special education? If so, when, where and what kind? _____

Has your child ever been in remedial classes? If so, when, where and what kind? _____

Has your child ever had special tutoring? If so, when, where and what kind? _____

Has your child ever received any other type of therapy? If so, please describe: _____

How many school days has your child been absent this semester? _____

Last school year_____ Previous school year? _____

Describe any school problems that you are presently aware of: _____

Activities

What things does your child like to do? _____

What things does your child do well? _____

What things present the greatest difficulty for your child? _____

Describe play indoors: _____

Describe play outdoors: _____

How does your child play and/or get along with other children? _____

Does she/he have friends? _____

Give detailed description of an average day: _____

Family History

Please indicate whether there are any relatives of the child (including parents, grandparents, aunts, uncles and cousins), who have the same or similar concerns for which you are seeking evaluation. Please indicate hyperactive as a child; trouble learning to read; trouble with math; trouble with writing; kept back in school; speech problems; mental retardation; behavior problems in childhood; in trouble as a teenager; depression; other mental illness; drinking problems or drug abuse.

Mother: _____

Mother's mother: _____

Mother's father: _____

Mother's brother(s) and sister(s): _____

Mother's brother's and sister's children: _____

Mother's aunts and uncles: _____

Mother's cousins: _____

Father: _____

Father's mother: _____

Father's father: _____

Father's brother(s) and sister(s): _____

Father's brother's and sister's children: _____

Father's aunts and uncles: _____

Father's cousins: _____

Describe any family tension: _____

_____

_____

_____

List support sources outside the family (relatives, friends): _____

_____

_____

_____

Future goals of child's mother: _____

_____

Future goals of child's father: _____

_____

Past Pregnancy History

Past pregnancies of child's mother: _____ Number of times pregnant: _____

Live births: _____ Still births: _____ Miscarriages: _____

List dates of past pregnancies. Indicate if there was a miscarriage, threatened miscarriage (bleeding), premature birth, twins (or other multiple births), deformity or other difficulty with live-born children, or any other complications.

Name	Birthdate	Birth Weight	Grade in School	Any school or Health Problems

Are the mother and father cousins or in any way related? _____

Previous marriage of either parent? If so, to whom, date and date of divorce: _____

Please list children of either parent born prior to this marriage:

Name	Birthdate	Birth Weight	Grade in School	Any school or Health Problems

Environment

Who lives in the home with the child? List age, relation and health:

List members of the family not living at home, where living and reasons:

Any recent major family problems such as death, illness, separation or accident?

Do you speak more than one language in the home?

Date of marriage of child's parents:

If applicable, date of separation: Date of divorce:

Step or adopted father: Birthdate:

Occupation: Religion:

Ethnic background: Years of schooling:

Health:

Step or adopted mother: Birthdate:

Occupation: Religion:

Ethnic background: Years of schooling:

Health:

Would you describe the relationship between co-parents as

Very good: Good: Average: Poor

Previous Evaluation

Please list below any previous evaluations (e.g. psychological, IQ, educational or achievement test, speech/language) that your child has had.

Place and Type of Evaluation	Address	Date

Please list the physicians who have seen your child:

Physician	Address	Date(s)	Reason for Consultation

Hospitalizations(s) of child:

Name of Hospital	Date	Age	Reason

Associated Behaviors

The following is a list of behaviors and characteristics. All children show some of these at sometime during their lives. To the right of each item, please put an "X" in the column which best describes this child during the past six months. Use the following key:

Definitely Applies = Much more frequently and/or extreme than others of the same age.
Applies Somewhat = A little more frequently and/or extreme than others of the same age.
Does Not Apply = Not different from others of the same age.
Do Not Know or Cannot Say = Does not describe the child.

	Behavior	Definitely Applies	Applies Somewhat	Does Not Apply	Do Not Know or Cannot Say
1	Is moody				
2	Has a bad temper				
3	Cries easily				
4	Is a worrier				
5	Has bad dreams				
6	Is often sad				
7	Is often very quiet				
8	Is fearful of new situations				
9	Is fearful of being alone				
10	Is often "down" on himself/herself				
11	Tried to sleep with parent(s)				
12	Is often tired				
13	Speaks unclearly, stutters or stammers				
14	Has stomach aches often				
15	Wets bed or pants often				
16	Soils underwear or has accidents with bowel movements				
17	Often has headaches				
18	Overheats often				
19	Bites nails				
20	Often complains of pains in arms or legs				
21	Has nervous twitches				
22	Complains of feeling ill often				
23	Has constipation				

Associated Behaviors

The following is a list of positive or good behaviors. Please indicate which of these pertain to your child by placing an "X" in the appropriate column to the right of each item.

	Behavior	Often True	Occasionally True	Seldom True	Cannot Say
1	Has an even disposition, is easy to live with				
2	Usually seems happy				
3	Enjoys new experiences				
4	Easily becomes involved in many activities				
5	Takes pleasure in many activities				
6	Is affectionate				
7	Is kind or sympathetic if someone else is sad or hurt				
8	Is friendly and outgoing				
9	Plays well with other children				
10	Shares or cooperates with others				
11	Accepts rules easily				
12	Is gentle with younger children and animals				
13	Makes friends easily				
14	Enjoys playing with other children				
15	Has many friends				
16	Takes turns well				
17	Tolerates minor bumps and scratches without much complaint				
18	Tolerates criticism well				
19	Confides in others about worries				
20	Is forgiving (does not "hold grudge")				
21	Does not take himself/herself too seriously				
22	Does not complain much when ill				
23	Compromises easily				
24	Stands up for himself/herself when necessary				
25	Recovers easily after disappointments				
26	Notices things that no one else does				
27	Is able to remember minor details better than most others				
28	Shows a great ability to recall things from long ago				
29	Has an excellent imagination				

NICHQ Vanderbilt Assessment Scale – Parent Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behavior in the past **6 months.**

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Please circle the appropriate number.

	Symptoms	Never	Occasionally	Often	Very Often
1	Does not pay attention to details or makes mistakes	0	1	2	3
2	Has difficulty keeping attention to what needs to be done	0	1	2	3
3	Does not seem to listen when spoken to directly	0	1	2	3
4	Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand(	0	1	2	3
5	Has difficulty organizing tasks and activities	0	1	2	3
6	Avoids, dislikes or does not want to start tasks that require ongoing mental effort	0	1	2	3
7	Loses things necessary for tasks or activities (toys, assignments, pencils or books)	0	1	2	3
8	Is easily distracted by noises or other stimuli	0	1	2	3
9	Is forgetful in daily activities	0	1	2	3
10	Fidgets with hands or feet or squirms in seat	0	1	2	3
11	Leaves seat when remaining seated is expected	0	1	2	3
12	Runs about or climbs too much when remaining seated is expected	0	1	2	3
13	Has difficulty playing or beginning quiet play activities	0	1	2	3
14	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15	Talks too much	0	1	2	3
16	Blurts out answers before questions have been completed	0	1	2	3
17	Has difficulty waiting his/her turn	0	1	2	3
18	Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19	Argues with adults	0	1	2	3
20	Loses temper	0	1	2	3
21	Actively defies or refuses to go along with adults' request or rules	0	1	2	3
22	Deliberately annoys people	0	1	2	3
23	Blames others for his/her mistakes or misbehaviors	0	1	2	3
24	Is touchy or easily annoyed by others	0	1	2	3
25	Is angry or resentful	0	1	2	3
26	Is spiteful and wants to get even	0	1	2	3
27	Bullies, threatens or intimidates others	0	1	2	3
28	Starts physical fights	0	1	2	3
29	Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30	Is truant from school (skips school) without permission	0	1	2	3
31	Is physically cruel to people	0	1	2	3
32	Has stolen things that have value	0	1	2	3
33	Deliberately destroys others' property	0	1	2	3
34	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3

NICHQ Vanderbilt Assessment Scale – Parent Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

	Symptoms (continued)	Never	Occasionally	Often	Very Often
35	Is physically cruel to animals	0	1	2	3
36	Has deliberately set fires to cause damage	0	1	2	3
37	Has broken into someone else's home, business, car	0	1	2	3
38	Has stayed out at night without permissions	0	1	2	3
39	Has run away from home overnight	0	1	2	3
40	Has forced someone into sexual activity	0	1	2	3
41	Is fearful, anxious or worried	0	1	2	3
42	Is afraid to try new things for fear of making mistakes	0	1	2	3
43	Feels worthless or inferior	0	1	2	3
44	Blames self for problems, feels guilty	0	1	2	3
45	Feels lonely, unwanted or unloved; complains that "no one loves him/her"	0	1	2	3
46	Is sad, unhappy or depressed	0	1	2	3
47	Is self-conscious or easily embarrassed	0	1	2	3

	Performance	Excellent	Above Average	Average	Somewhat of a problem	Problematic
48	Overall school performance	1	2	3	4	5
49	Reading	1	2	3	4	5
50	Writing	1	2	3	4	5
51	Mathematics	1	2	3	4	5
52	Relationship with parents	1	2	3	4	5
53	Relationship with siblings	1	2	3	4	5
54	Relationship with peers	1	2	3	4	5
55	Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only
Total number of questions scored 2 or 3 in questions 1 - 9: _____
Total number of questions scored 2 or 3 in questions 10 - 18: _____
Total Symptom Score for questions 1 - 18: _____
Total number of questions scored 2 or 3 in questions 19 - 26: _____
Total number of questions scored 2 or 3 in questions 27 - 40: _____
Total number of questions scored 2 or 3 in questions 41 - 47: _____
Total number of questions scored 2 or 3 in questions 48 - 55: _____
Average Performance Score: _____