Center for Therapeutic Intervention

Parent Questionnaire

Please fill this form out as fully and accurately as possible. The information you provide will enable your child's therapist to have a better understanding of your child. All of the information is kept in strict confidence.

Background Information

Child's name:			Birth Date:	Grade:
Any allergies?				
Parent's names:	Age:	Occupation:	Cell #:	Email Address:
(Address if different from child)				
1.				
2.				
Others living in home:				
Name:	Age:		Name:	Age:
Name:	Age:		Name:	Age:

Medical Information:

Referring Physician name:			Pediatrician:
Other Specialists involved with child: (Please include previous evaluations and current services)			
Name:	Date:	Reason:	Report Available? Yes / No

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Pregnancy and Birth History

While Pregnant did the mother have any illnesses?

List all medications taken during pregnancy:

Was the child early, on time, or late? How many weeks?

Were there any complications?

Weight at birth: Condition:

Is your child adopted/fostered? Yes / No When?
If YES, please describe contact/relationship with birth family.

Special circumstances:

Developmental History

Was your child bottle or breast fed? Any feeding difficulties?

At what age did your child first:

Sit Alone: Feed self-finger food:

Crawl: Speak first words:

Stand Alone: Speak sentences:

Walk Well: Completely toilet trained:

Has your child ever had the following: (Check all that apply and describe as necessary)

__Eye or Vision Problems __Meningitis __Ear or Hearing Problems
__Anemia __Allergies __Vomiting
__Asthma __Frequent Diarrhea __Convulsions or Seizures
__Frequent Colds __Head Injury

Has your child ever had surgery? Yes / No (If YES, please describe)

Are your child's vaccines up to date? Yes / No

Is your child on any medications? Yes / No Please list

Type and Dosage: Reason: Date Started:

School Information

Is your child currently in school or daycare? Yes/No
(If NO, who is the child home with?)

School: Grade:

Teacher's name: Other Specialists working with child:

Is your child in Special Education? YES/NO
Does your child have an IEP/504 Plan? YES/NO (If YES, Please provide a copy)

Does your child like school? YES/NO

What appears most difficult?

What does the child like best about school?

Does the child function better alone or in a group?

Social-Emotional Development

How does your child deal with frustration or anger?

Does your child tend to act out aggressively towards others?

How do you calm your child when they are upset?

How does your child tolerate transitions?

What methods are used to discipline your child? Are they effective?

What does your child like to do to occupy their time?

How much screentime /electronics does your child use on a daily basis?

Does your child have regular friends or playmates?

Does your child participate in:

Daycare After School Programs Summer Camps Sports Playgroups

Please describe:
_____
_____
_____
_____

Self Help Skills

Getting dressed
Independent Needs help with:_____

Bathing
Independent Needs help with:_____

Toilet training
Fully toilet trained Needs assistance wiping Still working on toilet training

Sleep Habits
Falls asleep easily Some difficulty Significant difficulty

Please describe bedtime routine:_____
_____
_____

Eating/Feeding
No problem Is picky at times Significant food aversions

Shoe tying
Independent Needs help with laces Doesn't know Left/Right Foot Needs total help

Handedness/Hand Dominance
Left Handed Right Handed Not developed yet

Household Chores:
Always Sometimes Never Please describe:

Please list in order of importance the major concerns you have in seeking help for your child:

1.

2.

3.

4.

5.

Person Completing Form: _____ Date: _____