

## 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	Background Information								
Child's name:			Birth Date:	Grade:					
Amu allamaia a 2									
Any allergies?									
Parent's names:	Age:	Occupation:	Cell #:	Email Address:					
(Address if different fro	m child)								
1.									
2.									
Oth It is a									
Others living in home:									
Name:	Age:		Name:	Age:					
Name:	Age:		Name:	Age:					
	J			Ğ					
Medical Information:									
Referring Physician nar	ne:		Pediatrician:						
Other Specialists involved with child: (Please include previous evaluations and current services)									
State. Specialists of teast with clinia. (Fieuse module previous evaluations and current services)									
Name:	Date:	Reason:	F	Report Available? Yes / No					

Pregnancy and Birth History		
While Pregnant did the mothe	r have any illnesses?	
List all medications taken d	uring pregnancy:	
Was the child early, on time, o	r late?	How many weeks?
Were there any complications	?	
Weight at birth:		Condition:
Is your child adopted/fostered If YES, please describe cont		When? pirth family.
Special circumstances:		
Developmental History		
Was your child bottle or breas	t fed?	Any feeding difficulties?
At what age did your child first	::	
Sit Alone:		Feed self-finger food:
Crawl:		-
Crawi.		Speak first words:
Stand Alone:		Speak sentences:
Walk Well:		Completely toilet trained:
Has your child ever had the fo	llowing: (Check all tha	t 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 surger	y? Yes / No (If YES, plea	ase describe)
Are your child's vaccines up to	date? Yes / No	
Is your child on any medication	ns? Yes / No Pleas	se 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?					

Social-Emotiona	al Development						
How does your child deal with frustration or anger?							
Does your child	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 Is picky at times No problem 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:** Sometimes Please describe: Always Never Please list in order of importance the major concerns you have in seeking help for your child: 1. 2. 3. 4. 5.