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Therapy Nurtures

nurturing roots and fostering growth

Parent Questionnaire about Your Child

Date:_____ Child's Name: _____
Chosen Name:_____ Date of Birth:_____
Child's preferred pronouns: _____ Child's Identified Gender:_____
Name of person completing this form:_____
Who suggested your child be evaluated? _____
What concerns do you have about you child? _____
_____
_____
_____
_____
_____

If the parents of the child are separated or divorced:
How long ago was the separation/divorce?_____
Who has custody of the child?_____
What is the visitation schedule?_____
_____

Trauma/Abuse History: (As a mandated reporter, I must report any current or past abuse instances to the appropriate authorities)
Has you child experienced any traumatic events?_____
_____
Has your child ever witness any domestic violence?_____
_____
Has your child been physically or sexually abused or neglected?_____
_____
Has your child been involved with Child Protective Services (CPS)? (If yes please describe the circumstances)_____
_____
Do you currently have a CPS case worker? (Please give the name and number)_____
_____

Birth History:

Was you child a full term pregnancy? (If born before due date, how early?_____# weeks)
Was your child born normal vaginal delivery or c-section?_____
Were there any problems during labor/delivery or following the birth? (Describe)_____
_____
Were there problems during the pregnancy?_____
_____
How much did the baby
weigh?_____
Were there any medications, drugs, or alcohol used during the pregnancy? (Please name)_____
_____

Developmental History:

y/n --Did your baby sit up by 8 months?_____
y/n --Did your child crawl by 10 months?_____
y/n—Did your child walk by 15 months?_____
y/n—Did your child speak single words or sentences by age 2?_____
y/n—Did your child read simple words by age 6?_____
y/n—Did your child cry frequently as an infant?_____
y/n --Was your child difficult to calm down as an infant?_____
_____
y/n—Did your child have frequent temper tantrums as an infant or toddler?_____
_____
y/n—Did your child have colic as an infant?_____
y/n—Was your child a picky or poor eater as an infant?_____
y/n—Is your child a picky eater now?_____
y/n—Has your child had/have bowel/stool problems?_____
y/n—Has your child had/have problems with bladder control (wetting)_____
_____
y/n—Has your child had/have problems falling, staying asleep, or waking up?_____
_____
y/n—Does your child have nightmares, night terrors, or sleepwalking?_____
_____
y/n—Has your child ever had tics or nervous twitches or made noises or sounds?_____

Medical History:

y/n—Has your child had major health problems? (describe)_____
_____
_____

y/n—Has your child been hospitalized? (explain)_____

_____

_____

y/n—Has your child had surgery? (explain)_____

_____

y/n—Has you child had frequent ear infections?_____

y/n—Has your child had/have vision, speech, or hearing problems?_____

_____

y/n—Has your child had a serious head injury or been unconscious?_____

_____

y/n—Has your child had seizures or epilepsy?_____

y/n—Has your child ever had broken bones or fractures?_____

_____

y/n—Has your child ever had problems with growth or weight or appetite?_____

Family Psychiatric History: Please mark if anyone in the immediate family or extended family has had one of the following and list who had this:

y/n--Depression_____

y/n--Bipolar Disorder_____

y/n--Schizophrenia_____

y/n—Autism or Pervasive Developmental Disorder_____

y/n --Tics or Tourette's syndrome_____

y/n—Obsessive Compulsive Disorder (OCD)_____

y/n—ADHD or Hyperacitvity_____

y/n—Substance or Alcohol Abuse_____

y/n—Learning Disability or Dyslexia_____

y/n—Anorexia/Bulimia/Eating Disorder_____

y/n—Legal Problems_____

y/n—Other Emotional or Mental Health Problems_____

Mental Health History:

y/n—Has your child ever seen a mental health therapist or counselor? (Give reason, names, and dates or age)_____

_____

_____

y/n—Has your child ever been seen by a psychiatrist? (Give reason, names and dates or ages)___

_____

_____

y/n—Has your child been treated with medication for a behavioral or mental health problem? (Give names of drugs, reason, and dates)_____

_____

y/n—Has your child ever been hospitalized for mental health treatment? (Give reason, places, and dates)_____
y/n—Does your child have a history of suicidal behavior or self-harming behaviors such as cutting, head banging, burning, etc.? (Describe)_____
_____
y/n—Does your child have a history of violence or aggression? (Describe)_____
_____
y/n—Does your child has a history of substance use or alcohol use? (Describe)_____
_____
_____

Is there anything I should know about your child, family, or that you feel is important?_____
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