# PATIENT QUESTIONNAIRE



Today's Date________________

Child's Name________________________________ Date of Birth________________

Cell Phone________________

Your Name________________________________ Home Phone________________

Relationship to Child________________________ Work Phone________________

Home Address________________________________________________

Name of Doctor________________________________________________

Doctor's Address________________________________________________

A. Please list the problems with which you want help for this child:

1. ________________________________________________
2. ________________________________________________
3. ________________________________________________
4. ________________________________________________
5. ________________________________________________
6. ________________________________________________
7. ________________________________________________
8. ________________________________________________

B. What have you said to the child about this evaluation?

________________________________________________

________________________________________________

C. Whose idea was it that this child have an evaluation?

________________________________________________

________________________________________________

________________________________________________

D. Has this child had previous evaluations outside of school? ❑ Yes ❑ No

If so, where and when? Please attach any previous report(s).

_______________________________________________

_______________________________________________

_______________________________________________

E. Has this child received any special treatments (diets, medications, psychological counseling, psychiatric help, etc.) outside of school? ❑ Yes ❑ No

If so, please describe below:

| Approximate Date(s) | TYPE(S) OF TREATMENT (Include name of any medicine your remember) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

The checklist entitled "Possible Pregnancy Problems" concerns the pregnancy with this child, except for items which refer to previous pregnancies (*). The "Newborn Infant Problems" checklist is about the baby's first month of life. Please reach read each list; then put an X in the appropriate column following each item.

| POSSIBLE PREGNANCY PROBLEMS | TRUE | NOT TRUE | CANNOT SAY |
|---|---|---|---|
| Had bleeding during first three months | | | |
| Had bleeding during second three months | | | |
| Had bleeding during last three months | | | |
| Gained 30 or more lb (14 kg) (specify) | | | |
| Had protein urine or elevated blood pressure | | | |
| Had to take medications* | | | |
| Vomited often | | | |
| Got hurt or injured | | | |
| Gained less than 15 lb (7kg) (specify) | | | |
| Took narcotic drugs e.g. cocaine, marijuana, etc | | | |
| Drank alcohol | | | |
| Had previous miscarriages (*) | | | |
| Had previous premature baby(ies) (*) | | | |
| Had an infection | | | |
| Smoked 1 pack (or more) of cigarettes/day | | | |
| Had a Caesarean section | | | |
| Had a difficult delivery (specify) | | | |
| Was put to sleep for delivery | | | |
| Length of labor | | | |
| Length of pregnancy ______ months | | | |

*Specify any medications:

1. ______________________________

2. ______________________________

Other pregnancy problems/illnesses:

1. ______________________________

2. ______________________________

| NEWBORN INFANT PROBLEMS | TRUE | NOT TRUE | CANNOT SAY |
|---|---|---|---|
| Born with cord around neck | | | |
| Injured during birth | | | |
| Had trouble breathing | | | |
| Got yellow (jaundice) | | | |
| Turned blue (cyanosis) | | | |
| Was a twin or triplet | | | |
| Had an infection | | | |
| Was given medications | | | |
| Had seizures (fits, convulsions) | | | |
| Had diarrhea | | | |
| Needed oxygen | | | |
| Was in hospital more than 7 days | | | |
| Gagged often | | | |
| Vomited often | | | |
| Born with heart defect | | | |
| Born with other defect(s) | | | |
| Had trouble sucking | | | |
| Had skin problems | | | |
| Was very jittery | | | |
| Baby's birth weight ________ lb [ ] kg [ ] | | | |

Baby's Apgar scores (1) __________(5)__________ (10)__________

Please list any other newborn problems:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

# PATIENT QUESTIONNAIRE



Following are two checklists about problems parents sometimes have with young children. The checklist entitled "Health Problems" is about any medical problems the child may have had. The "Functional Problems" checklist includes personality or behavioral problems the child may have had. In both lists, if the child has had any of these problems, 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 the child has never had the problem, put an X in the "Never" column.

| HEALTH PROBLEMS | N/A | 0-3 M | 4-6 O | 7-12 N | 13-18 T | 19-24 H S | 2-3 Y E | 3-4 A | 5-7 R | 7+ S |
|---|---|---|---|---|---|---|---|---|---|---|
| Ear infection(s) | | | | | | | | | | |
| Rashes or skin problems | | | | | | | | | | |
| Meningitis | | | | | | | | | | |
| Seizures/convulsions/spells | | | | | | | | | | |
| High fevers (over 103 degree) | | | | | | | | | | |
| Pneumonia | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Slow weight gain | | | | | | | | | | |
| Trouble with ears or hearing | | | | | | | | | | |
| Trouble with eyes or vision | | | | | | | | | | |
| Bowel problems | | | | | | | | | | |
| Hospitalization(s)* | | | | | | | | | | |
| Surgery (operations)* | | | | | | | | | | |
| Serious injury(ies) | | | | | | | | | | |
| Allergies | | | | | | | | | | |
| Sleep Difficulty | | | | | | | | | | |
| Anemia (low blood count) | | | | | | | | | | |
| Lead poisoning | | | | | | | | | | |
| Other poisoning or overdose | | | | | | | | | | |
| Heart problems | | | | | | | | | | |
| Kidney or urinary problems | | | | | | | | | | |

*Please give reasons for hospitalization(s) or surgery(ies):______________________

______________________________________________________________

Other Illnesses: ______________________________________________________

Who lives in your household?

| NAME | RELATIONSHIP TO PATIENT | AGE | ILLNESS |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

List any relatives with neurological, school, or mental health problems

| RELATIONSHIP | PROBLEM |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Following is a checklist of early accomplishments of children. Please put an X next to each item under the column giving the age at which this "milestone" first occurred. If there are items the child still cannot do, please leave all the columns blank.

| EARLY DEVELOPMENT | N/A | Age | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Sat up without help | | | | | | | | | |
| Crawled | | | | | | | | | |
| Walked alone (10-15 steps) | | | | | | | | | |
| Rode a tricycle | | | | | | | | | |
| Caught a big ball | | | | | | | | | |
| Spoke first words (Mama, Dada, etc.) | | | | | | | | | |
| Put words together (Mama, home, Daddy bye-bye, etc.) | | | | | | | | | |
| Spoke 2-3 word sentences | | | | | | | | | |
| Spoke clearly so strangers understood | | | | | | | | | |
| Used fingers to feed self | | | | | | | | | |
| Used a spoon | | | | | | | | | |
| Fully bowel trained | | | | | | | | | |
| Fully bladder trained | | | | | | | | | |
| Able to dress self | | | | | | | | | |
| Able to tie shoelaces | | | | | | | | | |
| Able to separate easily from mother (or school, play, etc.) | | | | | | | | | |

Did this child attend a preschool/nursery school? ❑ Yes ❑ No

If so, were any problems with behavior noted? ❑ Yes ❑ No

Were any problems with learning noted? ❑ Yes ❑ No

Was this child ever retained in a grade? ❑ Yes ❑ No

If so, when? ____________________

What is the principal language spoken at home? ____________________

Indicate other languages that are used sometimes____________________

For Children With School or Behavior Problems

# PARENT QUESTIONNAIRE

Directions: Indicate the degree to which each item below is a problem. Please respond to all items.

| | Never | Sometimes | Often | Very Often |
|---|---|---|---|---|
| 1. Doesn't pay attention to details, makes careless mistakes | 0 | 1 | 2 | 3 |
| 2. Difficulty paying attention | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen | 0 | 1 | 2 | 3 |
| 4. Difficulty following instructions, does not finish things | 0 | 1 | 2 | 3 |
| 5. Difficulty getting organized | 0 | 1 | 2 | 3 |
| 6. Avoids doing things that require a lot of mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things | 0 | 1 | 2 | 3 |
| 8. Easily distracted | 0 | 1 | 2 | 3 |
| 9. Forgetful | 0 | 1 | 2 | 3 |
| 10. Fidgets with hand or feet; squirms in seat | 0 | 1 | 2 | 3 |
| 11. Difficulty remaining seated | 0 | 1 | 2 | 3 |
| 12. Runs about or climbs on things | 0 | 1 | 2 | 3 |
| 13. Difficulty playing quietly | 0 | 1 | 2 | 3 |
| 14. "On the go", acts as if "Driven by a motor" | 0 | 1 | 2 | 3 |
| 15. Talks excessively | 0 | 1 | 2 | 3 |
| 16. Blurts out answers to questions | 0 | 1 | 2 | 3 |
| 17. Difficulty awaiting turn | 0 | 1 | 2 | 3 |
| 18. Interrupts others or butts into their activities | 0 | 1 | 2 | 3 |

## ACADEMIC PERFORMANCE

| | Problematic | | Average | Above Average | |
|---|---|---|---|---|---|
| Reading | 1 | 2 | 3 | 4 | 5 |
| Mathematics | 1 | 2 | 3 | 4 | 5 |
| Written expression | 1 | 2 | 3 | 4 | 5 |
| Homework completion | 1 | 2 | 3 | 4 | 5 |

## CLASSROOM BEHAVIOR

| | | | | | |
|---|---|---|---|---|---|
| Relationship with peers | 1 | 2 | 3 | 4 | 5 |
| Following directions/rules | 1 | 2 | 3 | 4 | 5 |
| Disrupting class | 1 | 2 | 3 | 4 | 5 |
| Assignment completion | 1 | 2 | 3 | 4 | 5 |
| Organizational skills | 1 | 2 | 3 | 4 | 5 |

Please include any observations you feel are pertinent.______________________________

______________________________________________________________

Date: ______________________

Child: ______________________________________

Person Completing this Form ______________________________

# TEACHER QUESTIONNAIRE

**(Please have child's teacher complete)**

Directions: Indicate the degree to which each item below is a problem. Please respond to all items.

| | Never | Sometimes | Often | Very Often |
|---|---|---|---|---|
| 1. Doesn't pay attention to details, makes careless mistakes | 0 | 1 | 2 | 3 |
| 2. Difficulty paying attention | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen | 0 | 1 | 2 | 3 |
| 4. Difficulty following instructions, does not finish things | 0 | 1 | 2 | 3 |
| 5. Difficulty getting organized | 0 | 1 | 2 | 3 |
| 6. Avoids doing things that require a lot of mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things | 0 | 1 | 2 | 3 |
| 8. Easily distracted | 0 | 1 | 2 | 3 |
| 9. Forgetful | 0 | 1 | 2 | 3 |
| 10. Fidgets with hand or feet; squirms in seat | 0 | 1 | 2 | 3 |
| 11. Difficulty remaining seated | 0 | 1 | 2 | 3 |
| 12. Runs about or climbs on things | 0 | 1 | 2 | 3 |
| 13. Difficulty playing quietly | 0 | 1 | 2 | 3 |
| 14. "On the go", acts as if "Driven by a motor" | 0 | 1 | 2 | 3 |
| 15. Talks excessively | 0 | 1 | 2 | 3 |
| 16. Blurts out answers to questions | 0 | 1 | 2 | 3 |
| 17. Difficulty awaiting turn | 0 | 1 | 2 | 3 |
| 18. Interrupts others or butts into their activities | 0 | 1 | 2 | 3 |

## ACADEMIC PERFORMANCE

| | Problematic | | Average | Above Average | |
|---|---|---|---|---|---|
| Reading | 1 | 2 | 3 | 4 | 5 |
| Mathematics | 1 | 2 | 3 | 4 | 5 |
| Written expression | 1 | 2 | 3 | 4 | 5 |
| Homework completion | 1 | 2 | 3 | 4 | 5 |

## CLASSROOM BEHAVIOR

| | | | | | |
|---|---|---|---|---|---|
| Relationship with peers | 1 | 2 | 3 | 4 | 5 |
| Following directions/rules | 1 | 2 | 3 | 4 | 5 |
| Disrupting class | 1 | 2 | 3 | 4 | 5 |
| Assignment completion | 1 | 2 | 3 | 4 | 5 |
| Organizational skills | 1 | 2 | 3 | 4 | 5 |

Please include any observations you feel are pertinent. ______________________________

______________________________________________________________

# GENERAL HISTORY (SUMMARY)

**PLEASE FILL IN OR CIRCLE ANSWERS BELOW:**

BIRTH WEIGHT: ____________ PREMATURE: Y N ILL: Y N

DEVELOPMENT: NORMAL: Y N DELAYS: Y N

MEDICATION ALLERGIES: Y N IF YES, PLEASE LIST:

______________________________________________

HOSPITALIZATIONS:

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________

SURGERY:

1. ______________________________________________
2. ______________________________________________

**REVIEW OF SYSTEMS: CIRCLE IF THERE ARE PROBLEMS:**

HEAD, SINUS, EAR, THROAT, NECK, EYES, VISION, GLASSES, TEETH, THYROID, HEART, ABDOMEN, BONES, JOINTS, FEVERS,

OTHER: ______________________________________________

FAMILY HEALTH: ______________________________________________

______________________________________________

SUBSTANCE ABUSE? ______________________________________________

LIST MEDICATION(S) AND DOSAGES: ______________________________

______________________________________________

OTHER COMMENTS:

______________________________________________