Harbor Children's Therapy, L.L.C.

# PARENT QUESTIONNAIRE

Child's Legal Name:________________________________________
Date of Birth:________________________________________
Current Age: ________________________________________
Home Phone Number:________________________________________
Cell Phone Number: ________________________________________
Mother's Work Phone Number: ________________________________________
Father's Work Phone Number: ________________________________________
E-mail Address:________________________________________

Address:________________________________________
Street City State Zip Code

Father's Name ________________________Birth Date ________________
Occupation ________________________________________
Mother's Name ________________________Birth Date ________________
Occupation ________________________________________
Legal Relationship of Parents to Patient (please check):

| | | |
|---|---|---|
| Natural Parent: | Mother: __________ | Father __________ |
| Adoptive Parent | Mother: __________ | Father __________ |
| Step-Parent | Mother: __________ | Father __________ |
| Foster Parent: | Mother: __________ | Father __________ |

All persons living in the home:

| Name | Age | Relation to patient | Highest Grade Completed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PARENTAL CONCERNS**

Please describe the major concerns you have in seeking help for your child. List your concerns in order of their importance to you.

1. (Most important) ________________________________
2. ________________________________________
3. ________________________________________
4. ________________________________________
5. ________________________________________

Does the concerns you have for your child interfere with his/her daily routines at home/school? If yes, please explain how.________________________________________
________________________________________

**MEDICAL HISTORY**

Child's Pediatrician or Family Doctor ________________________________
Address ________________________________________
Street City State Zip Code
Phone Number ____________________
Referred by ________________________________________

Please list any other doctors or other professional that have examined this child:

Name Address Purpose of Examination (Diagnosis given)

______________________________________________________________________________

______________________________________________________________________________

**PREGNANCY HISTORY**

While pregnant did child's mother have any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| German measles | ________ | _________ | Any severe emotional problems | _____ | _____ |
| Anemia (low iron) | ________ | _________ | Vaginal infection or bleeding | _____ | _____ |
| Diabetes | _______ _ | _________ | Have a high fever | _____ | _____ |
| Kidney Problems | ________ | _________ | Smoke Cigarettes | _____ | _____ |
| High Blood Pressure | ________ | _________ | Drink Alcohol | _____ | ______ |

What medication did child's mother take during pregnancy? (Include vitamins and iron):

______________________________________________________________________________

______________________________________________________________________________

Has child's mother ever experienced a miscarriage? ________________________________

If yes, did miscarriage precede or follow pregnancy with this child? _____________________

**BIRTH HISTORY**

Was the child born ________________ early __________________ late _____________on time?

Was child born by C-Section ______________ Yes ______________No If yes, please give reason for C-section:

_______________________________________________________________

_________________________________________________________________________________

How long was mother in labor? _____________________________________________

Birth weight: ____________ Length: _________________

Were there complications for the mother or baby at birth? _________Yes _________No

If yes, please describe ____________________________________________________________________________

______________________________________________________________________________

Has the child ever had the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Eye or vision problems | ___________ | ________ | Anemia | _________ | ________ |
| Ear or hearing problems | ___________ | ________ | Vomiting spells | _________ | ________ |
| Allergies | ___________ | ________ | Frequent diarrhea | _________ | _______ |
| Asthma | ___________ | ________ | Frequent colds | _________ | ________ |
| Convulsions or "Spells" | ___________ | ________ | Strain on urination | ________ | ________ |
| Head Injury | ___________ | ________ | Meningitis | ________ | ________ |

Has child had any other health problems not listed above? (Describe)

______________________________________________________________________________

______________________________________________________________________________

Does child take medication on a regular basis? _____________ Yes ____________ No

Please list medication taken, amount and reason for use: ___________________________________________________

______________________________________________________________________________

Please list below the name of the hospital where your child was born. Please list any other hospitalizations:

HOSPITAL ADDRESS YEAR REASON

1. ______________________________________________________________________

2. ______________________________________________________________________

3. ______________________________________________________________________

**DEVELOPMENT**

At what age did child first:

Sit alone ______________ Feed self finger foods __________________

Crawl (hands & feet) ______________ Speak first real words __________________

Stand alone ______________ Speak first real sentences _________________

Walk well ______________ Become completely toilet trained __________

**SELF CARE**

Describe any difficulties in your child's morning or bedtime routine:
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Does your child nap during the day? ______Yes ______No Length and time of nap _______________________

Does your child demonstrate difficulty going to sleep at night? ______Yes ______No

Does your child typically wake during the night? _______Yes _______No

How many hours of sleep does your child typically get at night? __________________

Is your child able to do any of the following independently:

| | | |
|---|---|---|
| Undress self | Yes___________ | No_____________ |
| Dress self | Yes___________ | No_____________ |
| Manage zippers, snaps, buttons | Yes___________ | No_____________ |
| Tie shoes | Yes __________ | No_____________ |
| Feed self | Yes___________ | No_____________ |
| Eat a variety of foods | Yes ___________ | No ____________ |
| Use utensils for eating | Yes___________ | No_____________ |
| Play by self | Yes ___________ | No ____________ |
| Bathes self | Yes ___________ | No ____________ |

If answered "No" to any of the above questions, please provide more detail ____________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

**SCHOOL HISTORY**

Is child currently enrolled in a school program? _______________ Yes _______________No

If yes, please answer the following:

School Name: ___________________________________________________________________

Address: ________________________________________________________________________

School Phone number: ____________________________________________________________

Grade (if applicable): _____________________________________________________________

Teacher's Name: __________________________________________________________________

Has child been evaluated by school diagnostic team? _______________ Yes ____________ No

If yes, when was the evaluation completed? _____________________________________________

Does the child currently have I.E. P. goals within the school district? __________Yes _________No

Please describe child's performance at school. What subjects does he do well in:_________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

What subjects does he have difficulty with?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Are there behaviors in the classroom that have been of concern to his teacher? ____Yes ____No

If yes, please describe _________________________________________________________________________
_______________________________________________________________________________________________

Are there any other family members (distant or close) with developmental or learning differences? ____Yes ____No

If yes, please describe _________________________________________________________________________
_______________________________________________________________________________________________

**SOCIAL-EMOTIONAL DEVELOPMENT**

Does child exhibit behaviors at home or school that concern you? ____________Yes __________No.

If yes, please describe the behaviors that concern you and an example of a situation where this behavior has interfered:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

What methods are used to discipline child? ________________________________________
_______________________________________________________________________________
___________________________________________________________

Are these methods effective? _______________Yes _______________________No

What types of activities does your child typically choose to occupy his/her time?
_______________________________________________________________________
_______________________________________________________________________

Does child have regular playmates or friends? ______________Yes ___________________No

Describe any difficulties your child may have in social situations:
___________________________________________________________________________

Describe your child's strengths:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

**INSURANCE INFORMATION**

Name of Insurance Company: ___________________________________________________

Subscriber Name: _________________________________________________________

Policy Number:___________________________________________________________

Group Number:___________________________________________________________

Referring Physician:_______________________________________________________

Billing address to send claims: _____________________________________________

If applicable, child's diagnosis:_____________________________________________

Subscriber's Social Security Number: _________________________________________

Person completing questionnaire: _____________________________________________

Relation to child: _________________________________________________________

Parent/Guardian Signature __________________________________________Date:_________