Center for Children and Families

Women and Infant's Hospital
Behavior and Development Clinic
50 Holden Street, 1st Floor
Providence, RI 02908

Parent's Questionnaire

Name of Child: ________________________________ **Date of birth:** ___________________________

Gender: Male Female

Form Completed by:____________________________ **Relation to Child:**________________________

Today's Date:__________________________

Briefly describe your reasons for contacting the Behavior and Development Center. What are your specific concerns?

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Were you referred to the Behavior and Development Center? Who? What were their primary concerns?

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Family Information

A. Family Information:

(1) Mother: Name: ____________________ Age: ___________ Date of Birth:______________

Mother's Education:
_______ Less than 12th Grade
_______ Completed High School
_______ Partial College
_______ Associates degree (2- year degree)
_______ College Degree (4- year degree)
_______ Graduate/ professional degree

Mother's Current Occupation: ____________________________________

(2) Father: Name: ________________ Age: ______ Date of birth:___________________

Father's Education:
________ Less than 12th Grade
________ Completed High School
________ Partial College
________ Associates degree (2- year degree)
________ College Degree (4- year degree)
________ Graduate/Professional degree

Father's Current Occupations: ____________________________________

(3) Parent's Marital Status:
______ Married (date__________________)
______ Single
______ Separated (date__________________)
______ Divorced (date__________________)

(4) Siblings:

Please provide information about the child's siblings in the chart below:

	Name	Age	DOB	M/F	Comments
1.					

2.					
3.					
4.					
5.					

(5) Living arrangement:

Who does the child live with?

	Name	Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Relationship options:
-Mother/ step mother
-Father/ step father
- Boy/ girlfriend (Significant other)
- Siblings
- Half sibling
- Step sibling
- Other extended Family (grandparent, Aunt/ uncle, cousin)

(6) Is the child adopted? Yes No If "yes", date(s) of adoption:____________________

(7) Has the child been in a foster placement? Yes No If "yes", date(s) of placement:_________________

(8) If parents live separately, describe arrangement ____

____

(B) Family Medical History

Please indicate who in your immediate or extended family has (or had) any of the following:

	Yes	Relation to child:		Yes	Relation to child:
Stuttering			Alcohol problems		
Speech/language delay			Drug Abuse		
Motor difficulties			Tics/Tourette's disorder		
Behavior problems			Seizures/Epilepsy		
Learning difficulties (LD)			Birth defects		
Mental retardation			Genetic problems		
Developmental delay			Hearing problems		
Cerebral Palsy (CP)			Endocrine Problems		
Autism/PDD			Thyroid disease		
AttentionProblems (ADHD)			Heat disease		
Eating disorders			High blood pressure		
Emotional Problems			Allergies		
Depression			Diabetics		
Anxiety			Asthma		
Manic depression/ bipolar			Cancer		
Schizophrenia			HIV/AIDS		
Psychiatric hospitalization					

Pregnancy and Birth Information:

A. Please provide information about mother's pregnancy history:

		Number
1.	Pregnancies (total number)	
2.	Miscarriages	
3.	Abortions	
4.	Still Births	
5.	Premature Births	

B. Birth and Neonatal Information:

(1) Basic Information:

(a) **Duration of pregnancy**: ________weeks

(b) **Type of delivery:** vaginal Cesarean (describe
Reason): ______________________________

(c) **Birth weight**:______________

(d) **APGAR scores**: 1 Minute _______, 5 Minutes_________

(e) **Medications during labor**: _____________________________

(f) **Discharged from hospital at** __________ (days/ weeks) **after birth**

(2) During pregnancy, did you (mother) use any of the following?

	Yes	No	Describe (what, when, amount, etc.)
Prescription medications			
Tobacco			
Alcohol			
Marijuana			

Other drugs during pregnancy:

(3) During pregnancy, did you (mother) have or experience any of the following?

	Yes	No	Describe, if necessary
Amniocentesis			
Toxemia (high blood pressure, eclapsia			

Significant vaginal bleeding			
Significant trauma or abdominal injury			
Hospitalization			
German Measles			
Infections			
Placenta previa			
Placental abruption			

Other complications during pregnancy:

(4) Was labor and delivery complicated by any of the following?

	Yes	No	Describe, if necessary:
Inducted labor			
Long labor			
Fetal Distress			
Use of forceps			

Other significant complications:

(5) During your baby's neonatal period (i.e., after birth), did he/she have any of the following?

	Yes	No	Describe, if necessary:
Prematurity			
Low birth weight			
In the special care nursery (NICU)			
Jaundice			
Problems breathing			
Required oxygen			
Sucking problems			
Swallowing problems			
Feeding problems			

Intraventricular bleeding			

Other significant complications:

Developmental Milestones

A. As best as you can recall, when did your child first:

	Age	**Comments**
Sleep Through the Night		
Sit Alone		
Crawl		
Walk Alone		
Babble		
Use Single Words		
Combine Words or 2-Word Phrases		
Speak in Sentences		
Bladder Trained		
Bowel Trained		

B. Has your child ever lost skills or abilities that he/she had previously acquired? If "yes", describe:

____

____

C. As an infant did your child experience (or does he/she now experience) any of the following?

(1) Feeding Difficulties: Yes No Please describe: ___________________________________

____

____

a) Was your infant breast fed? Yes No If yes, for how long? __________________________

b) Was your formula fed? Yes No If yes, did he/she require formula changes?

Please describe ____

(2) Colic: Yes No Please describe: ____

____

(3) Excessive Crying: Yes No Please describe: __________________________________

____

(4) Sleep Problems: Yes No Please describe: ___________________________________

____

Child's Medical History

A. Basic Information

1. Who is the child's pediatrician? _______________________________________

2. Is he/she under the regular care of another physician (e.g., neurologist, cardiologist, etc

   ____

3. Has your child ever been hospitalized? Yes No

   If "yes", provide the following information?

Date	Reason for Hospitalization:

B. Has your child had any of the following? Check all that apply.

	Yes	Describe/Date(s)
Sleep Problems		
Allergies		
Asthma		

Ear Infections		
Seizures		
Staring / Absence Spells		
Hearing Impairment		
Visual Problems		
Lead Poisoning		
Slow Weight Gain / Weight Loss		
Frequent Accident/Injuries		
Head Injury		
Loss of Consciousness		
Visits to Emergency Room		
Measles'		
Chicken Pox		

Other Significant complications:

C. Past Tests and Evaluations

(1) Please describe any previous evaluations (e.g., neurology, psychology, speech/language, occupational therapy). Please provide the (1) date of evaluation, (2) type of evaluation, and (3) a brief summary of what you know of the results/conclusions.

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(2) Has your child had any of the following tests? Check all that apply.

	Yes	Date/ Results
CT Scan		
MRI		
EEG (brain wave)		
Genetic Testing		
Allergy Testing		
Hearing Test		
Vision Test		

Other Medical Tests:

(3) Prescription medications that your child has taken or is taking:

√ if current	Medication	Dosage	Dates(s)	Prescribed by:

(4) Has your child ever received Early Intervention Services? If "yes", which Center provided services?

____

____

(5) Has your child ever had any of the following treatments or therapies?

Treatment	**Dates**	**Frequency (hours or sessions per week)**	**Provider**
Occupational/Physical Therapy			
Speech/Language			
Behavioral Therapy			
Family Therapy			

Psychotherapy			
Sensory Integration			
Auditory Training			
Social Skills Therapy			

Other (please describe):

(6) Have you used alternative medicines, treatments, or remedies? If yes, describe:

____

____

____

School/Daycare History

A. Please provide information about your child's current and past daycare and /or school placements:

√ if current	Name	Dates	Grade (if applicable)	Comments

Are there any problems at school or daycare? If yes, describe: ________________________________

____

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B. Does your child have an Individualized Educational Plan (IEP)? If yes, please provide date(s) of the IEP and describe services provided as part of the plan.