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Parent Form

Today's Date _____

Child's Name: _____ Mother's Name _____
Date of Birth _____ Father's Name _____
Child's Sex □ Male □ Female □ Married □ Single □ Divorced □ Never Married
Age _____ Custody Arrangement: sole / Joint-lives w/ _____
Is this child adopted □ Yes □ No
Home Address _____
Grade _____ MD's Name _____
Name of School _____ MD's Address _____
School Address _____
MD's Phone Number _____

Please list the problems you want help with for this child

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

Has your child been evaluated at school?	□ Yes □ No	If Yes? When and by whom?	
Is your child currently suspended	□ Yes □ No	Have they been suspended in the last year	□ Yes □ No
Did they attend preschool/nursery school			□ Yes □ No
Was this child ever retained in a grade (is so which _____)			□ Yes □ No
What is the primary language spoken at home? _____			

Has this child had any special treatments (diets, counseling, medication management?	☐ Yes ☐ No
Approximate Date(s)	Type of Treatment (include the name of any medicine you can remember)

Possible Pregnancy Problems	True	Not True	Cannot Say
Had bleeding during first trimester			
Had bleeding during second trimester			
Had bleeding during last trimester			
Had toxemia			
Had to take medications (if so what)			
Got hurt or injured			
Took narcotic drugs			
Drank much alcohol			
Had previous miscarriage			
Had previous premature baby(ies)			
Had an infection			
Smoked one pack (or more) of cigarettes a day			
Labor lasted longer than 12 hours			
Had a cesarean section			
Had a difficulty delivery			
Length of pregnancy _____ months			
Did you have any other illnesses (please specify)			

Newborn Infant Problems please put a check in the box that applies	True	Not True	Cannot Say
Born with cord around neck			
Injured during birth			
Got yellow (jaundice)			
Turned blue (cyanosis)			
Was a twin or triplet			
Had an infection			
Was given medications			
Has seizures			
Needed oxygen			
Was in the hospital for more than 5 days			
Born with heart defect			
Born with other defect (please specify)			
Baby's birth weight _____ lbs			
Please list any other medical problems			

Health Problems please put a check in each box that applies	Never	0-1 years	1-2 years	2-5 years	6-10 years	11-15 years	>15 years
Ear Infections							
Rashes or skin problems							
Meningitis							

Seizures							
Health Problems please put a check in each box that applies	Never	0-1 years	1-2 years	2-5 years	6-10 years	11-15 years	>15 years
High fevers (over 103 F)							
Pneumonia							
Asthma							
Slow weight gain							
Troubles with ears or hearing							
Trouble with eyes or vision							
Bowel problems							
Hospitalization(s) - if so, what for							
Surgery- if so, what for							
Head injury/other injuries							
Food allergies							
Other allergies							
Lead poisoning							
Other poisoning							
Heart problems							
Kidney or urinary problems							

Early Life Problems please put a check in each box that applies	Never	0-1 years	1-2 years	2-5 years	6-10 years	11-15 years	>15 years
Shyness with strangers							
Refusal to go to school/daycare							
Difficulty keeping to a schedule							
Problems going along with changes in daily routine							
Extreme restlessness							
Tendency to become overexcited							
Tendency to overreact							
Temper tantrums							
Irritability							
Cried often and easily							
Difficulty making eye contact							
Yelled a lot							
Too happy or too sad							
Head banging							
Self-destructive behavior							
Easily distracted							
Failure to be affectionate							
Makes odd sounds, grunts or noises							
Impulsive – says or does things without thinking							
Jerking of head or arms							
Eating nonfoods							
Poor appetite							
Constipation							
Stomach aches							
Trouble falling asleep							
Trouble staying asleep							
Snoring in sleep							
Frequent naps during the day							
Problems sustaining attention							

Overactivity							

Early Development please put a check in the box that applies	On time	Early	Late	Not yet achieved
Sat up				
Crawled				
Walked alone				
Walked up stairs				
Rode a bike				
Spoke first words				
Spoke 2 -3 word sentences				
Spoke clearly so strangers could understand				
Used fingers to feed self				
Used a spoon				
Fully bladder trained				
Fully bowel trained				
Able to dress self				
Able to tie shoelaces				
Able to separate easily from mother				

Father's present age _____ School level completed _____
Present occupation _____

Mother's present age _____ School level completed _____
Present occupation _____

Brother's names and ages _____

_____

_____

Sister's names and ages _____

_____

_____

Has this child endured an extremely stressful experience? If so what _____

_____

Related issues please put a check in each box that applies	Does not apply	Applies somewhat	Definitely applies
Is moody			
Worries a lot			
Seems sad			
Makes negative comments about self			
Has many fears			
Goes from very sad to very excited unpredictably			
Has ideas that are too big or grandiose			
Panics easily			
Has lost interest in things he/she used to enjoy			
Has talked about killing himself/herself			

Complains of headaches			
Goes through certain rituals or odd habits regularly			
Related issues please put a check in each box that applies	Does not apply	Applies somewhat	Definitely applies
Wets bed			
Makes odd sounds			
Has frequent twitches or tics			
Frequently complains of feeling tired			
Is rejected by others of his/her own age			
Relates better to younger or older children			
Says and does things that annoy peers			
Has trouble forming relationships			
Spends a lot of time alone when not in school			
Gets picked on or bullied			
Lacks close friends			
Refuses to accept responsibility			
Disobeys parents			
Is mean to animals			
Argues a lot			
Has temper tantrums			
Won't follow rules			
Fights with other children			
Uses bad language excessively			
Is mean to sibling/s			
Takes thing from others without asking			
Has been arrested			
Is sexually active			
Has used alcohol			
Smokes cigarettes			
Has used illegal substances			
Often overreacts			
Has difficulty paying close attention to detail			
Makes careless mistakes			
Difficulty sustaining attention			
Does not seem to listen			
Does not follow through on instructions			
Difficulty organizing tasks or activities			
Avoids or dislikes tasks requiring sustained mental effort			
Loses things			
Easily distracted			
Forgetful in daily activities			
Fidgets with hands or feet			
Leaves seat when should be sitting			
Hyperactive			
Difficulty playing quietly			
On the go or acting like he/she is driving by a motor			
Talks excessively			
Blurts out answers			
Difficulty awaiting a turn			
Interrupts or intrudes on others			