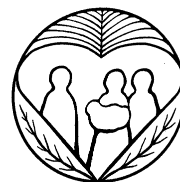

Child Attention Learning and Behavior Disorder
Parent Intake Questionnaire

Child's Name: ____

Birth Date: _____/_____/_____ Age: ________ Sex: ☐ Female ☐ Male

Person Completing Form: ____

Relationship to Child: ______________________ Phone: ____________________

Child's School: ______________________ Phone: ____________________

Current Grade: __________ Teacher's Name: ______________________

Briefly describe the child's behavior and learning problems that you want help for:

____

____

____

When did these problems begin? ____

Who suggested that your child be evaluated?

Name: ______________________ Phone: ____________________

Has your child seen anyone else for these problems? ☐ Yes ☐ No

If yes, who? Please list name and profession, example: doctor, counselor, teacher, etc.):

____

____

____

Who does the child currently live with (please list everyone in household):

Name/Relationship to Child	Name/Relationship to Child

PARENTS

MOTHER: ____ Age: ____________

Occupation: __________________________________ Work Phone: ____________________

Highest level of education completed: ____

History of learning problems? ☐ Yes ☐ No

If yes, please describe: ____

____

History of Attention, Mood or Behavior problems? ☐ Yes ☐ No

If yes, please describe: ____

____

Medical Problems: ____

Have any of the mother's blood relatives had problems similar to those the child is experiencing?

☐ Yes ☐ No If yes, please describe: ____

____

FATHER: ____ Age: ____________

Occupation: __________________________________ Work Phone: ____________________

Highest level of education completed: ____

History of learning problems? ☐ Yes ☐ No

If yes, please describe: ____

____

History of Attention, Mood or Behavior problems? ☐ Yes ☐ No

If yes, please describe: ____

____

Medical Problems: ____

Have any of the father's blood relatives had problems similar to those the child is experiencing?

☐ Yes ☐ No If yes, please describe: ____

____

SIBLINGS

Name: ____ Age: ____________

Name: ____ Age: ____________

Name: ____ Age: ____________

Name: ____ Age: ____________

Do any of the child's siblings have medical, social or school problems? ☐ Yes ☐ No

If yes, please list name and describe problems: __________________________________

____

____

ADDITIONAL FAMILY HISTORY

Do any of the patient's family (parents, brothers, sisters, aunts, uncles, grandparents, cousins) have a history of the following conditions:

	List Who		List Who
Mental Retardation	____________________	Sudden Death	____________________
Tourette's Syndrome	____________________	Seizures	____________________
Schizophrenia	____________________	Alcoholism	____________________
Autism/Aspergers	____________________	Suicide	____________________
ADHD	____________________	Thyroid Disease	____________________
Depression	____________________	Blindness	____________________
Manic/Depressive	____________________	Deafness	____________________

PREGNANCY

Excessive Vomiting: ☐ Yes ☐ No   Hospitalization Prior to Delivery: ☐ Yes ☐ No

Excessive blood loss: ☐ Yes ☐ No   Threatened Miscarriage: ☐ Yes ☐ No

Preeclampsia/Toxemia: ☐ Yes ☐ No   Smoking During Prenancy: ☐ Yes ☐ No

Alcohol Use in Pregnancy: ☐ Yes ☐ No   Drug Use During Prengnancy: ☐ Yes ☐ No

Infections (specify): ____

Operations (specify): ____

Other illnesses (specify): ____

Medications taken during pregnancy: ____

X-Ray studies during pregnancy: ____

Duration of Pregnancy: ☐ Premature # Weeks: ____ ☐ Full Term ☐ Postdates # Weeks ____

DELIVERY

Where: ______________________________ Doctor's Name: __________________________

Birth Weight: ___________________

Type of Labor: ☐ Spontaneous ☐ Induced Duration _________ hours

Complications: ☐ Infection ☐ Hemorrhage ☐ Infant injured during delivery

☐ Other: ____

POST DELIVERY PERIOD

☐ Jaundice (turned yellow) ☐ Cyanosis (turned blue) ☐ Incubator Care

☐ Infection (specify): ____

# of days infant was in the hospital after delivery: _______________

INFANCY PERIOD

☐ Breast Fed How long? _____________ ☐ Formula

Did your child have any special problems during the first year of life? _____________________

____

____

MEDICAL HISTORY

Has your child had any history of the following? Please explain yes answers:

Operations/Hospitalizations: ☐ Yes ☐ No ______________________________________

Head Injuries: ☐ Yes ☐ No ____

Convulsions: ☐ Yes ☐ No ____

Eye Problems: ☐ Yes ☐ No ____

Ear Problems: ☐ Yes ☐ No ____

Allergies or asthma: ☐ Yes ☐ No ____

Heart Murmur: ☐ Yes ☐ No____

Tics: ☐ Yes ☐ No ____

Exposure to Lead: ☐ Yes ☐ No ____

Hallucinations: ☐ Yes ☐ No ____

Digestive problems (heartburn, bloating, gas): ☐ Yes ☐ No ________________________

Abdominal pain: ☐ Yes ☐ No ____

Chronic Constipation or Diarrhea: ☐ Yes ☐ No __________________________________

Drug Use: ☐ Yes ☐ No ____

Other: ____

SLEEP

Is getting to sleep at a regular time a problem? ☐ Yes ☐ No

What is your child's bed time? ________________

Does your child have trouble getting to sleep? ☐ Yes ☐ No

Does your child have trouble staying asleep? ☐ Yes ☐ No

What time does your child wake up on school days? _________ Weekends? _________

Does your child snore? ☐ Yes ☐ No

When asleep, does your child have a period when he/she stops breathing for more than 15 seconds followed by catch up breathing? ☐ Yes ☐ No

Is there a family history of sleep apnea? ☐ Yes ☐ No

Does your child have bedwetting? ☐ Yes ☐ No

Does your child seem tired/sleepy during the day? ☐ Yes ☐ No

PRESENT MEDICAL STATUS

Present illnesses/conditions your child is being treated for: ________________________

____

Medications child is currently taking on an ongoing basis: ________________________

____

ACADEMIC ISSUES

How would your rate your child's overall intelligence compared to other children of the same age? ☐ Below average ☐ Average ☐ Above Average

Your estimate of your child's problems with learning:
☐ No problem ☐ Somewhat of a problem ☐ Major problem

What subjects does your child struggle with? ___________________________________

____

What subjects does your child do well with? ___________________________________

____

Do you think your child understands directions and situations as well as other children his/her age? If not, why? ____

____

Do you have any concerns about your child's current level of coordination or athletic ability? ____

ACADEMIC ISSUES , Continued

Do you have any concerns about your child's academic performance: ________________

____

____

When did these concerns initially develop? ______________________________________

____

Do you have concerns about your child's behavior at school? _____________________

____

____

When did these concerns initially develop? ______________________________________

____

PEER RELATIONSHIPS

Does your child seek friendships with peers? ____________________________________

Is your child sought by peers for frienships? ____________________________________

Does your child have friends? ☐ Few ☐ Some ☐ Many

Does your child play with children his/her: ☐ Own Age ☐ Younger ☐ Older

Describe any problems your child may have with peers: __________________________

____

____

HOME BEHAVIOR

How many hours a day does your child spend:

On the computer ______________ Reading ___________________

Watching TV _________________ Playing outside ____________

Playing video games ___________ Alone _____________________

How many dwellings has your child lived in during the past 3 years? ________________

How many schools has your child attended in the past 3 years? ____________________

Are there firearms in the home? ☐ Yes ☐ No

Is your child exposed to: ☐ Drugs ☐ Smoking ☐ Abuse ☐ Violence ☐ None

Is food/shelter/clothing/safety a concern? ☐ Yes ☐ No

HOME BEHAVIOR, Continued

Does your child create more problems (deliberate or non-deliberate) in the home than his/her siblings? ____

____

Type of discipline you use with your child: ____

____

Is there a particular form of discipline that has proven effective? ____________________

____

Have you participated in parenting classes or read books about discipline and behavior management? ____

____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? __________________________________

____

What are your child's areas of greatest accomplishments? ___________________________

____

What is your child's most positive quality? ____

____

Is there anything else you would like us to know? __________________________________

____

____

____

____

____

____

____

____