Kranz Psychological Services, PLLC

PARENT QUESTIONNAIRE

Dear Parent: Date:___________________

It is the desire of our staff to have the most complete picture possible of your child in order to better understand his or her problems. This questionnaire will help you give us the information we need to help you and your child. Please inform office staff if you are unsure of how to answer a question.

Questionnaire completed by:____

Relationship to the child:____

DEMOGRAPHIC INFORMATION

Name of Child:____

Date of Birth:_____________________________Sex:_____________Age:__________________

Race: ________________Grade:__________School:_____________________________________

Address:____Phone:________________

With whom does the child live? (Check all that apply.)

	YES	NO	
Biological Mother	____	____	
Biological Father	____	____	
Stepmother	____	____	
Stepfather	____	____	
Foster Mother	____	____	
Foster Father	____	____	
Adoptive Mother	____	____	
Adoptive Father	____	____	
Residential Treatment Facility	____	____	How Many? _____
Biological Siblings	____	____	How Many? _____
Foster Siblings	____	____	How Many? _____
Other Adults	____	____	How Many? _____
Other Children	____	____	How Many? _____

Who has custody of this child?____

Is the child currently in CPS care? YES NO

If you are a foster parent, how long has this child lived with you?_______________________

If you are an adoptive parent, how old was the child at the time of adoption?_______________

MEDICAL & DEVELOPMENTAL HISTORY

Did the child's mother have any complications during pregnancy or at birth? YES NO UNSURE
If yes, what type of complications?:____

Did the child's mother experience high stress during pregnancy? YES NO UNSURE
If yes, please describe:____

Did the child's mother use tobacco, illicit drugs, or alcohol during pregnancy? YES NO UNSURE
If so, please describe:____

Did the child have complications at birth? YES NO UNSURE
If yes, what type of complications?____

Please list the ages at which this child met the following developmental milestones (If you do not know the ages at which this child met the developmental milestones, please write "unknown"):

Crawling:___________________________ Walking:____________________________
Said Single Words:____________________ Toilet Trained:_______________________
Said Sentences:_______________________ Menstruation (if female):_______________

Does the child currently wet himself/herself at night? YES NO
If yes, how often?______________________________
Does the child currently wet himself/herself at during the day? YES NO
If yes, how often?______________________________
Does the child currently soil himself/herself? YES NO
If yes, how often?______________________________

Describe any serious illnesses or accidents requiring a hospital visit/stay (birth complications, falls, burns, broken bones, seizures, asthma etc.) this child has had and his/her age at the time:
____
____

How often does the child see a medical doctor?____

Does the child see any of the following health care providers?

Pediatrician	YES	NO
Neurological Examiner	YES	NO
Psychologist/Psychiatrist	YES	NO
Counselor/Therapist	YES	NO

What medications is the child taking?____

Does the child wear glasses? YES NO
If yes, at what age did he/she begin wearing them?________________________________

Describe any other vision problems the child has:____

Does the child wear hearing aids? YES NO
If yes, at what age did he/she begin wearing them?________________________________

Describe any other hearing problems the child has:_______________________________________

Has the child attended speech therapy? YES NO
If yes, when and where?____

Describe any speech problems the child has:____

EATING & SLEEPING HABITS

Does this child have a good appetite? YES NO

Is the child typically hungry at mealtime? YES NO

Does the child have to be coaxed to eat? YES NO

Does the child binge on food? YES NO

Does the child vomit often? YES NO

Does the child complain about his/her body weight? YES NO

What time does the child wake up in the morning?____

What time does the child go to bed?____

Does the child resist going to bed? YES NO

Does the child complain of nightmares often? YES NO
If yes, what are the nightmares about?____

Does the child appear to get restful sleep? YES NO

Does the child take a nap during the day? YES NO

Does the child share a bedroom? YES NO
If yes, with whom?____

DISCIPLINE IN THE HOME

Who most often disciplines the child?____

What discipline is most often used?____

What discipline works best?____

What discipline works least?____

What is the child's most common reaction to being disciplined?_________________________
____

PLAY, ACTIVITIES, & WORK

With what age of children does this child play *most* often? YOUNGER OLDER SAME

With what gender does this child prefer to play? BOYS GIRLS BOTH

What games, recreation, or hobbies does the child enjoy? ______________________________
____

Is the child involved in activities outside the home? YES NO
If yes, what? (e.g., clubs, church groups, etc.)__________________________________

Is the child required to complete chores at home? YES NO
If yes, please list chores:____

SCHOOL

Has the child repeated a grade? YES NO
If so, which grade(s)?____

Is the child currently failing any classes? YES NO
If so, which one(s)?____

Does the child receive special education services? YES NO
If so, which classes?____

Does the child receive 504 services? YES NO

Does the child willingly do his/her homework? YES NO

Does the child misbehave in class? YES NO
If yes, often do you receive a note, phone call, or other indication from the child's teacher/principal (such as "color changes") about problematic behaviors?_____________

Does the child get along with classmates? YES NO

Does the child get along with teachers and other adults? YES NO

Does the child like school? YES NO

FAMILY RELATONSHIPS & HISTORY

Describe how the child gets along with the following (fill out only those that apply):

Biological Mother:____
Biological Father:____
Stepmother:____
Stepfather:____
Foster Mother:____
Foster Father:____
Adoptive Mother:____
Adoptive Father:____
Siblings in the Home:____

Has anyone in the child's ***biological*** family experienced the following (check all that apply)?:

	MOM	DAD	EXTENDED FAMILY
Alcohol Abuse	_____	_____	_____
Drug Use	_____	_____	_____
Intellectual Disability	_____	_____	_____
Perpetrator of Abuse	_____	_____	_____
Legal Convictions	_____	_____	_____
Mental Illness	_____	_____	_____

HISTORY OF ABUSE & NEGLECT

Has the child been sexually abused? YES NO UNSURE

If yes, who was the perpetrator and when did the abuse occur?______________________
____

Has the child been physically abused? YES NO UNSURE

If yes, who was the perpetrator and when did the abuse occur?______________________
____

Has the child experienced neglect (emotional or physical)? YES NO UNSURE

If yes, who was the perpetrator and when did the abuse occur?______________________
____

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ADULT / CHILD COMMUNICATION

Does the child talk freely to you about his/her problems?	YES	NO
Does the child seek comfort from a caregiver when upset?	YES	NO
Does the child accept comfort from a caregiver when upset?	YES	NO
Does the child seek interaction with unfamiliar adults?	YES	NO
Is the child "overly friendly" (verbally or physically) with strangers?	YES	NO
Does the child stay close to his/her caregiver in unfamiliar surroundings?	YES	NO
This child is more difficult to parent than other children I have cared for.	YES	NO
As a parent/caregiver, I feel overwhelmed by this child's problems.	YES	NO

CAREGIVER'S VIEW OF THE CHILD'S PROBLEMS / STRENGTHS

Has the child used drugs or alcohol within the past six months? YES NO UNSURE

If yes, please describe:____

List what you believe are the child's 3 main problems:

1.____

2.____

3.____

List what you believe are the child's 3 best strengths:

1.____

2.____

3.____

Briefly describe any additional information about this child you feel would be helpful in evaluating and treating him/her.

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