Chapel Hill Pediatric Psychology, P.A.
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PARENT QUESTIONNAIRE

Date________________Form Completed By___________________________________________

Child's Full Name ______________________________Gender_______ Birthdate______

Address__________________________________________________________________________
Street City State County Zip

Who referred the child?________________Child's Primary Physician______________________

Parent 1:__________________________ Birthdate_________

Address (if different from above)__________________________________________________

E-mail address______________________________

Home Phone__________________Can we leave a message w/a person? Y/N voice-mail? Y/N

Cell Phone ___________________Can we leave a message w/a person? Y/N voice-mail? Y/N

Occupation__________________ Employer___________________Educational Level_________

Work Phone_________________Can we leave a message w/ a person? Y/N voice-mail? Y/N

Parent 2:________________________ Birthdate________

Address (if different from above)_______________________________________

E-mail address______________________________

Home Phone_________________Can we leave a message w/a person? Y/N voice-mail? Y/N

Cell Phone ___________________Can we leave a message w/ a person? Y/N voice-mail? Y/N

Occupation__________________ Employer ___________________ Educational Level________

Work Phone__________________Can we leave a message w/ a person? Y/N voice-mail? Y/N

Marital Status ________ If parents are separated or divorced: Separation/Divorce Date__________

With whom does the child live? [ ] Birth parents [ ] Adoptive parents [ ] Foster parents
[ ] Grandparents [ ] Other_________________________________
Who has physical custody? ____________________ Legal custody? ______________________

Name of Insurance Company: _____________ Member ID/Policy Number: ____________________

Name of Policy Holder: ______________________________ Policy Holder DOB: _______________

May we contact the child's primary physician?
[ ] To receive information
[ ] To give information ___________________________
(Signed) Parent or Guardian

**Note: Please complete all information on this report. All information is treated in confidence and will not be released without your permission.**

List all other persons living in the home:

| Name: | Age: | Relationship to Child: | Present Health: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

List any other people who care for the child a significant amount of time:

| Name: | Relationship to Child (grandmother, neighbor, etc.): |
|---|---|
| | |
| | |

Has social services ever been involved with your family? [ ]Yes [ ] No: If yes, please elaborate:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**CHILD**

Pregnancy and Birth: Any Complications? [ ]Yes [ ] No: If yes, briefly explain: ____________________

______________________________________________________________________

______________________________________________________________________

Developmental Milestones: (Ages) Sitting: _______ Walking:_______Toilet Trained: _______

Speak First Words:_______ Use 2-3 Word Phrases:_______ Full Sentences: _______

Medical Problems: [ ]Yes [ ] No; If yes, briefly explain: ______________________________________

______________________________________________________________________

Child's Last Physical Exam Date & Results: ______________________________________________

______________________________________________________________________

______________________________________________________________________

| FAMILY RECORD<br><br>Check (✓) condition and relationship of any blood relative who has or has had any of the conditions listed below: | NONE | CLIENT | BIO-FATHER | BIO-MOTHER | GRANDFATHER | GRANDMOTHER | BROTHER | SISTER | SON | DAUGHTER | OTHER | INDICATE OTHER RELATIVE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism/Substance Abuse | | | | | | | | | | | | |
| Allergies | | | | | | | | | | | | |
| Birth Defects | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | |
| Colitis | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | |
| Anxiety | | | | | | | | | | | | |
| Heart Attack | | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | | |
| Liver Disease | | | | | | | | | | | | |
| Migraines | | | | | | | | | | | | |
| Mental Illness | | | | | | | | | | | | |
| Seizure Disorder | | | | | | | | | | | | |
| Mental Retardation/Intellectual Disability | | | | | | | | | | | | |
| Autism/Asperger's | | | | | | | | | | | | |
| Developmental Disability | | | | | | | | | | | | |
| Learning Disorder | | | | | | | | | | | | |
| Attention Problems | | | | | | | | | | | | |
| Suicide/Suicide Attempt | | | | | | | | | | | | |
| Thyroid Problems | | | | | | | | | | | | |
| Eating Disorder | | | | | | | | | | | | |

| Family Member | Living? | Age | Current Health: Good | Fair | Poor | If Deceased, Cause of Death |
|---|---|---|---|---|---|---|
| Parent 1 | | | | | | |
| Parent 2 | | | | | | |
| Brothers | | | | | | |
| | | | | | | |
| Sisters | | | | | | |
| | | | | | | |

Please list any jobs or chores your child has at home or at school. (For example, feeding the dog, making the bed, hall monitor)

How well does your child do these jobs?

| [ ] None | Poor | | Average | | Great |
|---|---|---|---|---|---|
| 1. ______________________ | 1 | 2 | 3 | 4 | 5 |
| 2. ______________________ | 1 | 2 | 3 | 4 | 5 |
| 3. ______________________ | 1 | 2 | 3 | 4 | 5 |

What are your child's strengths? ______________________________________________

______________________________________________________________________

How many close friends does your child have? [ ]None [ ]1 [ ]2 [ ]3 [ ]4+

How many close friends in the neighborhood does your child have? [ ]None [ ]1 [ ]2 [ ]3 [ ]4+

How many times/week does your child do things with them? [ ]None [ ]1 [ ]2 [ ]3 [ ]4+

Compared to other children his/her age, how does your child get along with other children?

| Poor | | Average | | Great |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

What are your child's favorite recreational or extracurricular activities? ______________________

______________________________________________________________________

______________________________________________________________________

Who generally disciplines the child? ______________ What methods are used? ____________

______________________________________________________________________

Do parents agree on methods of discipline? [ ] Yes [ ] No; If no, please elaborate: ______________

______________________________________________________________________

**SCHOOL HISTORY**

Has child been enrolled in a nursery or day care? [ ] Yes [ ] No At what age? ___________

At what age did he/she enter first grade? ___________ What is present grade placement? ___________

If your child has ever been to school (including nursery, kindergarten, and grade school) complete the following for all grades beginning with nursery and ending with current placement. Please indicate if your child repeated or is in a special class (gifted/talented, learning disabled, behavior disordered, emotionally handicapped, etc.)

| Grade | School | Comments |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Current school performance (for children aged 6 and older):

[ ] Does not go to school

| | Failing | Below Average | Average | Above Average |
|---|---|---|---|---|
| a. Reading | | | | |
| b. Writing | | | | |
| c. Math | | | | |
| d. Spelling | | | | |
| e. Other academic subjects (history, science, foreign language, geography, etc.) | | | | |
| | | | | |
| | | | | |
| | | | | |

**PARENTAL CONCERNS**

What do you feel is your child's main problem? ____________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

What do you feel caused your child's problem? ____________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

What have you been told by doctors, teachers, and/or others about your child's problems? ___________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Has your child had any previous mental health evaluations, treatment, or diagnosis? If yes, by whom?

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Has any other member of your child's immediate family had mental health treatment? ________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________