Kidz Therapy Zone Parental Questionnaire

CLIENT/Child's INFORMATION

Child's Name:

Age:	Birth date:
Person filling out this form:	Relationship to client:
Who can we thank for this referral?	

FAMILY BACKGROUND

Mother's Name: _____ Age: _____
Occupation:_____
Marital Status: ❑ Single ❑ Widowed ❑ Divorced ❑ Married ❑ Separated
History of Medical and/or Speech or Language Problems? ❑ Yes ❑ No
If "Yes" please explain:_____

Father's Name: _____ Age: _____
Occupation:_____
Marital Status: ❑ Single ❑Widowed ❑ Divorced ❑ Married ❑ Separated
History of Medical and/or Speech or Language Problems? ❑ Yes ❑ No
If "Yes" please explain:_____

Brothers and Sisters:

Name	Age	Medical or Speech Problems?

Who is currently living in the home with your child?
❑ Biological Mother ❑ Biological Father ❑ Adoptive Parents ❑ Brothers ❑ Sisters
❑ Other (please specify) _____

Is any language other than English spoken in the home? ❑ Yes ❑ No
What is the primary language spoken at home? _____

Have there been any major changes in the family during the last year?
If yes, please specify i.e. changes of address, parent separation/divorce, accident, illness/death, births, adoptions, marriage, etc.

_____
_____
_____

FAMILY HEALTH

A large majority of learning issues and emotional disturbances are hereditarily based. Have any family members had any of the following? **If yes, please specify family member's relationship to this child.** If child is not living with biological parents, please include health information on biological parents if known.

Autism	ADHD/ADD
Fragile X Chromosome	Substance abuse
Cancer	Tourette's Disorder
Cystic Fibrosis	Down's Syndrome
Diabetes	Neurofibromatosis
Hypoglycemia	Seizures or epilepsy
Food allergies	Speech or language problem
Atmospheric Allergies	Attention Deficit Disorder
Multiple sclerosis	Muscular dystrophy
Other: Describe	

Mental Illness	Learning Challenges
Manic Depression	Math Computation
Schizophrenia	Math Concepts
Depression	Written Expression
Personality Disorder	Listening Comprehension
Anxiety	Reading Comprehension

Mania	Reading of Words
Bipolar Disorder	Spelling
Obsessive Compulsive Disorder	Handwriting
Other, please describe	Oral Expression

PRENATAL AND BIRTH HISTORY

During Pregnancy (Check any that apply):
❑ Excessive vomiting ❑ RH Incompatibility ❑ Drug use
❑ Alcohol use ❑ Hemorrhaging ❑ Smoking ❑ Illnesses
❑ High Blood Pressure ❑ Trauma or injuries ❑ X-ray Treatments
❑ Other _____

Labor and Delivery (Check any that apply):
❑ Full Term ❑ Breeched Presentation ❑ Premature: _____ weeks early
Birth Weight: _____ ❑ Normal Delivery ❑ Induced Labor
❑ Cesarean ❑ Prolonged Labor ❑ Forceps

Conditions affecting child <u>after</u> Birth (Check any that apply):
❑ Difficulty Breathing ❑ Difficulty Sucking ❑ Difficulty Feeding
❑ Seizures ❑ Birth Defect ❑ Extended Hospital Stay
❑ Jaundice ❑ Infections
❑NICU (how long) _____
❑Other _____

MEDICAL HISTORY
Has your child ever had the following?
❑ Ear Infection ❑ Tubes Inserted ❑ Allergies ❑ Asthma
❑ Head Injury ❑ Encephalitis ❑ Meningitis ❑ Seizures
❑ Other_____

List Medications your child is currently taking and why:
_____
_____

List any frequently occurring medical problems your child has:
_____

List any illnesses, injuries, or hospitalizations. Please include year.
_____
Does your child wear glasses? ❑ Yes ❑ No
Hearing Aides? ❑ Yes ❑ No

Do you suspect your child has a hearing loss? ❑ Yes ❑ No
If "yes" what behaviors led you to suspect this?
_____

Has your child's hearing ever been tested? ❑ Yes ❑ No
Location:_____ Date _____
Results: _____ Recommendations: _____

Has your child's vision ever been tested? ❑ Yes ❑ No
Location:_____ Date _____
Results: _____ Recommendations: _____

Has your child received services from any of the following professionals?
If so, please indicate from whom, where and when:

Speech-Language Pathologist: ❑ Yes ❑ No
_____
Physical/Occupational Therapist: ❑ Yes ❑ No
_____
Audiologist: ❑ Yes ❑ No
_____
Psychologist/Psychiatrist: ❑ Yes ❑ No
_____
Ear, Nose, Throat Doctor: ❑ Yes ❑ No
_____
Neurologist: ❑ Yes ❑ No
_____
Other: _____

SLEEP AND EATING HABITS:
Does your child sleep through the night? ☐ Yes ☐ No
On average, how long does it take your child to fall asleep? _____
Do they frequently wake throughout the night? _____

Please tell us more about your child's sleep habits/concerns:
_____
_____

Does your child eat a variety of fruit/vegetables/protein? ☐ Yes ☐ No
What are your child's favorite foods?
_____
_____

Do you have concerns over your child's feeding/eating habits? ☐ Yes ☐ No
Please explain:

_____

_____

PLAY BEHAVIORS

What is the average length of time your child can stay playing at one activity?_____

What activities seem to hold your child's attention for the longest period of time?

_____

_____

INTERESTS/ HOBBIES/MOTIVATORS:

What are your child's interests? Examples: letters, numbers, dolls, cars, puzzles, swings, dancing, singing, bubbles, you name it! (When we know more about the child, we are better able to create motivating, client-centered interventions.)

_____

_____

_____

SOCIAL AND EMOTIONAL BEHAVIOR

Check the behaviors that describe your child:

❑Overly quiet	❑Overly active	❑Excessive tantrums	❑Destructive
❑Very shy	❑Perfectionistic	❑Friendly/outgoing	❑Imaginative
❑Plays well with other children		❑Difficulty separating from parent	

Does your child…

Have problems relating to or playing with other children? ☐ Yes ☐ No
Have difficulty knowing the emotions of others? ☐ Yes ☐ No
Fight frequently with playmates? ☐ Yes ☐ No
Prefer playing with younger children? ☐ Yes ☐ No
Have difficulty making friends? ☐ Yes ☐ No
Have difficulty initiating/maintaining conversation? ☐ Yes ☐ No
Share easily with others? ☐ Yes ☐ No
Play creatively with toys? ☐ Yes ☐ No
Use play to imitate (playing house, answering the phone)? ☐ Yes ☐ No
Does your child play the same games repeatedly? ☐ Yes ☐ No

Does your child simply drop toys and walk away often? ☐ Yes ☐ No
Is your child rough/destructive with toys? ☐ Yes ☐ No
Participate in clean-up? ☐ Yes ☐ No
Prefer to play alone? ☐ Yes ☐ No
State they are lonely or wish for friendship ☐ Yes ☐ No
Comments:

Please rate child's level of…

Cooperation ☐ Good ☐ Fair ☐Poor	Tolerance of change ☐ Good ☐ Fair ☐Poor
Coping skills ☐ Good ☐ Fair ☐Poor	Anxiety/stress/fear ☐ Good ☐ Fair ☐Poor
Motivation ☐ Good ☐ Fair ☐Poor	Sadness ☐ Good ☐ Fair ☐Poor
Impulsivity ☐ Good ☐ Fair ☐Poor	Safety awareness ☐ Good ☐ Fair ☐Poor
Confidence ☐ Good ☐ Fair ☐Poor	Frustration levels ☐ Good ☐ Fair ☐Poor
Response to limit setting ☐ Good ☐ Fair ☐Poor	
Comments:	
Tantrums:	
Frequency: ☐Never ☐Seldom ☐Occasionally ☐Frequent	
Intensity: ☐Mild ☐Moderate ☐Severe	
Average # of "meltdowns" per day per week	
Comments:	
Aggression:	
☐ Never/Seldom	
☐ Verbal:	☐Loud ☐Yelling ☐Screaming ☐Crying ☐Saying hurtful things
☐ Physical:	☐Hit ☐Kick ☐Bite ☐Pinch ☐Slam door ☐Throw things ☐Tear paper ☐Damage property ☐Spit
Comments:	

Cognition:

How would you rate your child's ability to..			
Attend to a single task ☐ Fair ☐Poor		Initiate a task ☐ Fair ☐Poor	
Follow directions ☐ Fair ☐Poor		Count/ write #s ☐ Fair ☐Poor	
Sing/write the alphabet ☐ Fair ☐Poor		Read ☐ Fair ☐Poor	
Comments:			

EDUCATIONAL HISTORY

Does your child attend:

❑Preschool ❑Day care ❑Public school ❑Private school ❑Home schooled

Name of school: _____Address: _____

Grade/Level: _____ Teacher: _____

Name of childcare provider: _____

Address: _____

Is your child on an Individualized Education or Family Service Plan (IEP or IFSP)?

❑Yes ❑No

If so, what needs are addressed by the plan i.e. Speech/Communication, OT, PT:

Please provide us with the IEP if available!

_____

_____

Does your child enjoy school/childcare? ❑ Yes ❑ No

Please comment:_____

_____

_____

Are there any concerns reported by the teacher/care provider? ❑ Yes ❑ No

If so, please describe:_____

_____

_____

Is your child having any difficulty with:

❑ Learning to read ❑ Spelling ❑Telling stories ❑ Understanding emotions of others

Please explain: _____

SPEECH AND LANGUAGE DEVELOPMENT

Please also complete this section if you have concerns regarding your child's Speech and Language Development:

Indicate at what age your child demonstrated the following:
_____ Babbling _____Jargon (talking in own language)
_____ Single words _____Phrases _____Short sentences

What is the primary method your child uses for letting you know what he/she wants? Some of these may not be relevant for your child' current age. (please check any that apply):

- ❑ Looking at objects
- ❑ Pointing at objects
- ❑ Gestures and signs
- ❑ Crying
- ❑ Vocalizing
- ❑ Sentences
- ❑ Leads you to desired object
- ❑ Single words
- ❑ 2-3 Word combinations

Which of the following describes your child's speech? (Please give examples)

- ❑ Easy to understand: _____
- ❑ Difficult for mother to understand:_____
- ❑ Difficult for others to understand:_____
- ❑ Almost never understood by others:_____
- ❑ Different than other children of the same age:_____

If your child does not use words, please describe how s/he communicates:

Which of the following statements best describes your child's reaction to his/her speech?:

- ❑ Is easily frustrated when not understood
- ❑ Does not seem aware of speech/communication problem
- ❑ Has been teased about his/her speech
- ❑ Tries to say sounds or words more clearly when asked
- ❑ Is successful in saying sounds or words more clearly when he/she tries

Does your child have difficulty pronouncing certain sounds? ❑ Yes ❑No
If "Yes", which ones?_____
_____

Does your child hesitate and/or repeat sounds or words? ❑ Yes ❑ No
Does your child "get stuck" when attempting to say a word? ❑ Yes ❑ No

If so, please mark any behaviors that you have observed:

- ❑ Repeats individual sounds or syllables (ex. B-b-baby)
- ❑ Repeats single words (ex. My, my, my)
- ❑ Prolongs sounds (ex. Mmmmmmy)
- ❑ Repeats phrases (ex. Can I, can I, can I go?)
- ❑ Shows physical or emotional tension
- ❑ Blocks the sound at the beginning or middle of the word when trying to speak

Is there a family history of stuttering that you are aware of? Please explain.

_____

Does your child's voice frequently sound rough or hoarse? If yes please explain.

_____

Do you question your child's ability to understand directions or conversations?
❑ Yes ❑ No

Which of the following do you think your child understands? Some of these may not be relevant for your child' current age. (Please check any that apply)

❑His/her own name ❑Names of body parts ❑Family names
❑Names of objects ❑Simple directions ❑Complex directions
❑Conversational speech

Do you find it necessary to use gestures to help your child understand what you want? Please describe: _____

STATEMENT OF THE PROBLEM

Describe in your own words, the speech or language problem you feel your child is experiencing_____

_____

_____

When did you first notice the problem? _____

What is your child's awareness of/reaction to the problem?

_____

How do you and other family members react to this problem?

What information do you hope to gain from this evaluation and what specific questions or areas do you wish us to address?

_____

OCCUPATIONAL THERAPY DEVELOPMENT

Please also complete this section if you have concerns regarding your child's overall development:

EARLY DEVELOPMENT

At approximately **what age** did your child achieve the following milestones?

Sitting alone _____ Crawling _____ Standing alone _____
Walking alone _____ Using stairs _____ Feeding self _____
Potty trained for night _____ Potty trained for day _____
Were there any medical reasons for the bed wetting or soiling? If yes, please describe: _____

LATER DEVELOPMENT

From the age of 5 to the present time, were/are any special challenges noted in the following areas? **If yes, please describe**

Difficulty learning to ride a bike ☐ Yes ☐ No _____
Difficulty learning to skip ☐ Yes ☐ No _____
Difficulty following multiple directions ☐ Yes ☐ No _____

Which hand does your child use for:
Writing or drawing? ☐ Right ☐ Left
For Eating ☐ Right ☐ Left
For Throwing, Catching ☐ Right ☐ Left
If the child uses both, which is most preferred? ☐ Right ☐ Left

ACTIVITIES OF DAILY LIVING

Is your child able to independently…
Wash and dry his/her body ☐ Yes ☐ No Wash his/her hair ☐ Yes ☐ No
Do you have any bathing/showering concerns? ☐ Yes ☐ No
Comments:_____

Is your child able to independently…
Initiate toileting ☐ Yes ☐ No Wipe self ☐ Yes ☐ No
Sequence toileting tasks ☐ Yes ☐ No Wash his/her hands ☐ Yes ☐ No
Manage clothes during toileting ☐ Yes ☐ No
Manage clothing fasteners ☐ Yes ☐ No
Do you have any toileting concerns? ☐ Yes ☐ No

Is your child able to independently…
Brush his/her teeth ☐ Yes ☐ No Floss ☐ Yes ☐ No
Comb his/her hair ☐ Yes ☐ No

Do you have any hygiene/grooming concerns? ☐ Yes ☐ No
Comments:_____

Do you have any mobility/walking/running/stairs concerns? ☐ Yes ☐ No

Is your child able to independently…
☐ Put on shirt ☐ Take off shirt ☐ Put on pants ☐ Take off pants
☐Use zippers ☐Take off shoes ☐Tie shoes ☐Button/unbutton
☐ Put on shoes
Is your child picky with what they wear? ☐ Yes ☐ No
Do you have any dressing concerns? ☐ Yes ☐ No
Comments:_____

Feed him/herself ☐ Yes ☐ No
Use a spoon ☐ Yes ☐ No
Use a fork ☐ Yes ☐ No
Use a knife to spread ☐ Yes ☐ No
Use a knife to cut ☐ Yes ☐ No
Drink from a sippy cup ☐ Yes ☐ No
Drink through a straw ☐ Yes ☐ No
Prepare his/her own food? ☐ Yes ☐ No
Retrieve his/her own food? ☐ Yes ☐ No
Drink from an open cup ☐ Yes ☐ No
Comments: _____

Do you have any Sensory concerns for your child? ☐ Yes ☐ No
Please explain:
_____

_____

STATEMENT OF THE PROBLEM
Describe in your own words, the general development, learning, and/or sensory challenge you feel your child is experiencing:
_____

When did you first notice the problem?
_____

What is your child's awareness of/reaction to the problem?
_____

How do you and other family members react to this problem?

_____

What information do you hope to gain from this evaluation and what specific questions or areas do you wish us to address?
_____