ALL PEDIATRICS
4500 POND WAY
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WOODBRIDGE, VA 22192
703 436 1200

The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information, which you think, may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

Please use the backs of the pages for additional details.

GENERAL INFORMATION:

Today's Date:____________________Person Completing Form: ___________________________________

Child's Name:____Date of Birth:__________Age: ________

Home Address: ____

City____State__________Zip_________________

Home Phone: ____

Work Phone: Mother:_______________________________ Father: ______________________________

Cell Phone: Mother:________________________________ Father:______________________________

E-Mail: Mother:_____________________________________ Father:______________________________

School:______________________________________ System:___________________ Grade: ________

School's telephone number: ____

Teacher(s): ____

REASON FOR REFERRAL / CURRENT SYMPTOMS

Please describe the problems your child is now having and the type of services you are seeking.

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P*lease indicate if your child is experiencing any of the following difficulties:*

_________School attention/concentration

_________Problems Grades dropping or

_________Consistently low hyperactive,

_________Difficulty being still Impulsive,

_________Doesn't think before acting

_________Sadness or Depression

_________Generalized Anxiety (across many situations)

_________Specific

fears/phobias (list):

_________Social

__________Obsessive-Compulsive / Rigid behavior patterns

__________Body-focused repetitive behaviors (skin picking, hair pulling, nail biting,

__________Isolated socially from peers

__________Problems making or keeping

__________Friends Problems with eating

__________Problems falling asleep

__________Problems sleeping through the night (middle of the night or early morning

waking) Trouble waking up

__________Fatigue/tiredness during the day

__________Nightmares

__________Noncompliant, purposely does not obey (not due to language or cognitive

deficits) Oppositional, defiant behavior

__________Problems controlling temper

__________Tantrums / "Meltdowns"

__________Problems with authority (breaking rules or laws)

__________Wetting accidents (indicate day or night wetting):

__________Soiling accidents or other bowel problems (withholding, refusal,

__________fear/anxiety) History of abuse (emotional, physical, sexual)

__________Alcohol or drug use/abuse

__________Vocal or motor tics (e.g., grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

__________ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

__________Stress from conflict between

__________Parents Stress due to family

__________Financial problems legal situation

Other behavior problems: ____________________

PARENTS / GUARDIANS AND FAMILY INFORMATION:

Mother's Name: ____________________

Age: Occupation:____________________ Education Completed: ____________________

Health: Excellent Good Fair Poor

Father's Name:____________________ Age:

Occupation: Education Completed: ____________________

Health: Excellent Good Fair Poor

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single

if married, how long have you been married?____________________If divorced, how long have you been divorced?____________________If divorced, who has physical custody? ____________________

Is it full or joint? _____Who has legal custody? __________ Is it full or joint? ____________

Please provide a copy of the custody agreement.

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Where does this parent live?________________________________

If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody? Step Siblings?

____

____

How would you rate the quality ofyour present marriage?

Mother:____Great _____Very Good ______Good ____Fair ______Poor ____Very Poor

Father: __Great_____Very Good ____Good ____Fair ____Poor ______Very Poor

Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain:

____

Who supervises the child's care when not in school? _

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Siblings: List IN ORDER OF AGE siblings ofchild/adolescent for whom you are seeking services.

SiblingName	Age	School	Grade Placement	Grade Average	Conduct

(Pleaseindicategood,fair,orpoorconduct) In general, how would you say the child for whom you are seeking services gets along with these siblings?

______Great ______Very Good ____Good ____Fair ______Poor ____Very Poor Describe:

____

____

Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.).

Name	Age	Relationship to Child	Years Living in Home
________________	______	______________	From ______ to ______
________________	______	______________	From ______ to ______
________________	______	______________	From ______ to ______
________________	______	______________	

Are there other relatives who have a significant impact on how this child is raised?

____

FAMILY STRESS LEVEL

Please rate the overall level of FAMILY stress:

______Very Low   Low   ______Average   — —High   ______Very High

What is the greatest source of stress for the family at this time?

Please rate the overall level of stress in the mother's life:

______Very Low   Low   _____Average   ______High   ______Very High

What are the greatest sources of stress in the mother's life?

Please rate the overall level of stress in the father's life:

______Very Low   Low   ______Average   ______High   ______Very High

What are the greatest sources of stress in the father's life?

How would you rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Mother: _ _ _ _   Father: ____

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who.

	Condition	Family Member
	General Developmental Delays or Cognitive Delay	_____
___________	Speech or Communication Disorder	___________
___________	Intellectual Disability (mental retardation)	
___________	Attention-Deficit / Hyperactivity / Impulsivity	___________
___________	Learning Problems / Disabilities	___________
___________	Autism Spectrum / Asperger's Disorder	___________
	Sleep disorders	___________
___________	Generalized Anxiety (across many situations)	___________
___________	Social Anxiety	___________
___________	Obsessive-Compulsive Disorder	___________
___________	Phobias	___________
___________	Depression	___________
	Manic-Depression / Bipolar Disorder	___________
___________	Suicide attempts / Suicide	
___________	Schizophrenia or other psychosis	___________
___________	Alcohol / Substance Abuse	___________
	Seizures or other neurological disorder	___________
	Genetic Disorder (e.g., Down Syndrome, Fragile X) ___________	
___________	Other: ___________	

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

DEVELOPMENTAL HISTORY

Were there any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.

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Child was born: ______Premature _______Full term _____________Late

Birth Weight___________

Difficulties following delivery? ____

Nursery (check all that apply):____________Well-baby Transitional Intensive Care Other

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.)

Any medical problems diagnosed in inancy? ____

As an infant, did this child seem:

More Active than average__________

Less active than average____________

Overly active______________

As a toddler, did this child seem:

Less active than average__________

Average__________

Overly Active_____________

As a preschooler, did this child seem:

Less active than average___________

Average______________

Overly active________________

As the child entered school, did this child seem:

Less active than average___________

Average______________

Overly active________________

At what age did your child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet."

Speech and Language

Coo/babble_________

Respond to name_________

Say first word__________

Use,gestures,wave, point)____________

Put words together ____

Speak in sentences ___

Follow Simple directions

Follow_________

Multistep directions _____

Motor Skills

Roll over_________

Sit alone_________

Stand alone________

Walk alone_________

Hold pencil correctly ___

Self-Help/Independence

Feed self__________

Toilet train_________

(bladder)

Toilet

train (bowel)______

Dress Self_______

Bathe self_________

Social Skills

Smile at others_____

Laugh aloud________

Show affection_______

Engage in pretend play__________

Control feelings when upset________

Understand others'

feelings _______

Show

Responsibility__________

List any physicians or health professionals your child sees for services on a regular basis.

____

____

____

When did a physician last see your child?

____

Rate your child's overall health

Excellent Good Fair Poor

Child’s current height: ______ ft., ____ In. Weight: _____ lbs.

Does your child have any vision problems? _______________________________

Date of last vision test and who performed (physician, optometrist, school) _______________

Does your child have any hearing problems? _______________________________

Date of last hearing test and who performed (physician, audiologist, school) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Is your child: right handed Left handed does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.

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List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time. Use back of page if needed.

Describe your child's regular diet (i.e., favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating)?

What is your child's typical bedtime and wake time each day? Any concerns about your child's sleeping habits?

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?

EDUCATIONAL AND SOCIAL HISTORY

List in chronological order all schools your child has attended:

	Name of School	Dates Attended		Grade Placement	Grade Average	Behavioral Conduct
		From	To			
2.		From	To			
3.		From	To			
4.		From	To			
5.		From	To			

*(Please indicate good, fair, or poor conduct)

Name of current teacher(s):____

What concerns does your child's teacher have about him/her?

What is your child's favorite subject? ____

What is your child's least favorite subject? ____

Has your child ever repeated a grade? ____________________ If so, which? ____________________

Has your child ever skipped a grade? ____________________ If so, which? ____________________

Has your child ever had tutoring? __________ Which subjects? ____________________

When and with whom? ____

Has this child ever been in a Special Education Program?___________If yes, during what years__________________________

What type of program? (LD, Gifted, EBD, ASD, etc.): ____

Child's attitude toward school: ____

How does your child interact with peers and adults in social situations? Do you have any concerns about your child's social skills, or development

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List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

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Describe your child's strengths and positive qualities and any special abilities or skills.

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BEHAVIOR MANAGEMENT/ DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed.

	Very Likely				Very Unlikely
Let situation go	1	2	3	4	5
Time out	1	2	3	4	5
Send to room	1	2	3	4	5
Take away a privilege (ex. no TV)	1	2	3	4	5
Take away something material (ex. No dessert)	1	2	3	4	5
Assign an additional chore	1	2	3	4	5
Ground child	1	2	3	4	5
Reason with child /Problem-Solve/ Negotiate	1	2	3	4	5
Yell at child	1	2	3	4	5
Physical Punishment	1	2	3	4	5
List anything else you may do:	1	2	3	4	5

Please rate what percentage of discipline is handled by each of the following:

Father: % Mother: % Other %

Please go back and rate the three most effective strategies.

Please circle the least effective strategy.

Please list the five things you would like for your child to do more ofand less ofin order ofpriority to you. For example, instead ofsaying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often	Would like Child to do Less Often
1. ______	______
2. ______	______
3. ______	______
4. ______	______
5. ______	______

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain

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Is there anything else we should know about your child that was not covered by this form?

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