Caryn Garriga, MD
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Phone 636-527-8900 | Fax 636-527-8912

Parent Questionnaire

CHILD'S NAME:	
DATE OF BIRTH:	
FORMS COMPLETED BY:	RELATIONSHIP TO CHILD:
ADDRESS:	
CITY:	STATE: ZIP:
PARENT/GUARDIAN CELL:	PARENT/GUARDIAN CELL:
EMAIL ADDRESS:	
PARENT/GUARDIAN NAME:	PARENT/GUARDIAN WORK PHONE:
PARENT/GUARDIAN NAME:	PARENT/GUARDIAN WORK PHONE:
PARENTS' MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ UNMARRIED	
MEDICAL INSURANCE COMPANY:	
PRIMARY CARE DOCTOR:	FOR HOW LONG?:
WHO REFERRED YOU?	
What are your main concerns about your child? Please be specific.	
When did your concerns begin?	
What questions would you like answered?	

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What do you hope to gain from the evaluation?

Please include the names of other professionals, clinics, social services agencies, physicians or hospitals currently or previously involved with your child, along with evaluations and any diagnoses from them.

Professional/s Seen	**Diagnosis/Results**

FAMILY HOUSEHOLD MEMBERS

Name	**Relationship**	**Age**	**Living at home (Check)**	**Level of Education**	**Occupation/ Grade in school**	**Place of employment**

Does anyone else live with the family? **YES/NO** If so, who?

Are there members of your child's family (parents/siblings/grandparents/aunts/uncles/cousins) who have **Emotional problems, Mental Retardation, Seizures, Hyperactivity, Attentional Problems, Speech/Language Problems, Learning Problems, Autism, Asperger's, or those who have received Special Education Services?** If so, who?

Family Member in Relation to Child	**Diagnosis**

MEDICAL HISTORY

Child's Birth Weight:	Length of Pregnancy in Weeks:

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Were there any problems with the pregnancy, i.e.: hypertension, diabetes, infections? **YES/NO**
If yes, please describe:

Were there any problems with the labor or delivery? **YES/NO**
If yes, please describe:

Did biological mother take any medications, smoke cigarettes, drink alcohol or take drugs during pregnancy? **YES/NO**
If yes, please describe:

Has your child ever been hospitalized or had surgery? **YES/NO** If yes, please list when and for what reason:

Date	**Reason**

Does your child have any chronic medical problems? **YES/NO** If yes, please describe:

Is your child on any chronic medications? **YES/NO** If yes, please list:

Has your child had any problems in the following areas?

Vision/Eyes	YES/NO	If yes, please describe:
Hearing/Ears	YES/NO	If yes, please describe:
Weight: Underweight/Overweight	YES/NO	If yes, please describe:

PRESENT MEDICATIONS (PLEASE LIST BELOW):

Type	**Dosage**	**Reason**

PREVIOUS MEDICATIONS

Type	**Dosage**	**Why Stopped?**

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Has your child had any of the following? If yes, please explain:

Bedwetting/Soiling	YES/NO	Please explain:
Seizures/Convulsions	YES/NO	Please explain:
Problems with Sleep	YES/NO	Please explain:
Sensory Issues	YES/NO	Please explain:
Serious head injury/Periods of unconsciousness	YES/NO	Please explain:
Problems with eating (not accepting foods, difficulty feeding your child, rigidly selective in choice of foods, eating nonfood substances)	YES/NO	Please explain:

DEVELOPMENTAL HISTORY
Please complete to the best of your ability the age at which your child did the following:

Behavior	**Age**	**Behavior**	**Age**
Rolled over		Spoke in full sentences	
Sat alone		Speech understood by strangers	
Crept on hands and knees		Bladder trained for daytime	
Stood alone		Bowel trained	
Walked alone		Bladder trained at nighttime	
Said first word		Named colors	
Used 2-3 word phrases		Counted to 10	

Do you think your child's development has been normal? **YES/NO** If no, please explain:

Does your child exhibit repetitive behavior(s)? hand flapping, shaking movements, toe walking, strange eye movements, getting stuck on a topic, etc. **YES/NO** If yes, please explain:

Compared to the child's sibling/s, would you say your child has developed at (Circle One):

Same rate **Faster Rate** **Slower Rate**

Please explain:

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CURRENT FUNCTIONING
Does your child have difficulty in any of the following areas? *(If you answer yes, please explain further)*

Coordination/Balance motor skills (walking, running, skipping, climbing stairs, bike riding, catching/throwing)	YES/NO	Please explain:
Use of hands and fingers (reaching, grasping, and picking up small items, opening/closing items, playing with manipulative toys such as blocks)	YES/NO	Please explain:
Self-Help skills (feeding self, dressing, drinking from a cup, brushing teeth, washing hands, toileting)	YES/NO	Please explain:

SPEECH/LANGUAGE SKILLS *(If you answer no, please explain further)*

Does your child respond to sound?	YES/NO	Please explain:
Does your child respond to his/her own name?	YES/NO	Please explain:
Does your child speak in complete sentences?	YES/NO	Please explain:
Does your child speak clearly?	YES/NO	Please explain:
Does your child understand directions?	YES/NO	Please explain:
Does your child express himself/herself effectively?	YES/NO	Please explain:

SOCIAL/EMOTIONAL SKILLS *(If you answer no, please explain further)*

Does your child show interest in other children/adults?	YES/NO	Please explain:
Does your child make/maintain eye contact?	YES/NO	Please explain:
Does your child use pretend play?	YES/NO	Please explain:
Does your child get along with children their own age?	YES/NO	Please explain:

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Does your child get along with their siblings?	YES/NO	Please explain:
Does your child express himself/herself effectively?	YES/NO	Please explain:

BEHAVIORS

Does your child respond well to discipline?	YES/NO	Please explain:
Does your child have tantrums?	YES/NO	Please explain:
Is your child's activity level comparable to other children the same age?	YES/NO	Please explain:
Is your child aggressive?	YES/NO	Please explain:
Is your child destructive?	YES/NO	Please explain:
Does your child hurt himself/herself?	YES/NO	Please explain:
Does your child exhibit repetitive behavior(s)?	YES/NO	Please explain:

CHILDCARE/EARLY INTERVENTION

NAME OF SCHOOL AND/OR CHILDCARE PROGRAM:	
ADDRESS:	PHONE:
CURRENT TEACHER:	HOME SCHOOL DISTRICT:

Has your child ever been seen through your county's early intervention program?	YES/NO	When?
Has your child ever had an IEP?	YES/NO	When?
Has your child been reviewed by the Early Childhood Center?	YES/NO	When?

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Was your child classified by Early Childhood?	YES/NO	When?
Has your child ever received any 0-3 early intervention services (i.e. First Steps, Child & Family Connections)?	YES/NO	Please explain:
Did your child quality for early childhood services from 3-5?	YES/NO	
Has your child ever received (Circle all that apply): Speech Occupational Therapy Physical Therapy Developmental Therapy	YES/NO	When?
Has your child ever been asked to leave daycare or school?	YES/NO	If yes, please explain:

Does your child receive related services (speech/language therapy/occupational therapy, physical therapy/music therapy/counseling/adaptive physical education/etc.)? **YES/NO**

If yes, please fill out below:

Services Received	**How Often**	**Where?**

Does your child receive services from a special education teacher (inclusion classroom/integrated classroom/SEIT/special instruction/self-contained classroom)? **YES/NO**
If yes, please describe:

Has your child attended other school programs or child care centers before the current one? **YES/NO**
If yes, please list:

What are your child's strengths at the school and/or child care center they attend?

Are there concerns about your child's behavior at the school and/or child care center? **YES/NO**
If yes, please describe:

What suggestions or plans has the school program or child care center offered?

What are your feelings about how the school program or child care center has addressed your child's needs?

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Signature of parent or guardian: _____ Date: _____

Signature of parent or guardian: _____ Date: _____

Please note: If there is joint custody, signatures are required by BOTH parents

Please return the completed parent/educational and/or early intervention questionnaires, along with any other school reports, speech/occupational therapy evaluations and copies of doctor/therapist consults. Once we receive all of your completed information, we will call you to schedule an initial consultation.

Fax, mail or email to:

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