Kindelan McDanal & Associates

PSYCHOLOGICAL & COUNSELING SERVICES

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PARENT QUESTIONNAIRE

Date Completed: ____________________Child's Name: ____

Child's Age & Date of Birth: ____

Your Name: ____

Relationship to Child: ____

Parents' Names: ____

Mother's Address and Phone: ____

____

Father's Address and Phone: ____

____

Father's Occupation: ______________________________________Years of Education: _______________________

Mother's Occupation: _____________________________________Years of Education: _______________________

Parents are (check one): ☐ Together ☐ Separated ☐ Divorced Other: _________________________

Stepmother's Name: ____

Stepfather's Name: ____

Who referred you to counseling with Kindelan and Associates? ____

Are both parents aware that the child is participating in counseling? ___________________________________

Describe the problems which have led you to seek this consultation for your child: ________________________

____

What do you, personally, believe to be the most important factors causing these problems? ____________________

____

Have there been any family changes or difficulties (new baby, divorce, family arguments, etc.) which may be related to these problems? If so, please explain. ____

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____

Describe your child's **best** behavior traits: ____

____

____

____

CHILD BEHAVIOR INVENTORY

Below are a series of phrases that describe children's behavior. Please circle the number describing how often the behavior currently occurs with your child, and circle either "Yes" or "No" to indicate whether the behavior is currently a problem.

	How often does this occur with your child?							Is this a problem for you?	
	Never	**Seldom**	**Sometimes**		**Often**		**Always**		
Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
Does not obey house rules on his/her own	1	2	3	4	5	6	7	Yes	No
Refuses to obey until threatened with consequences	1	2	3	4	5	6	7	Yes	No
Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
Gets angry when does not get own way	1	2	3	4	5	6	7	Yes	No
Has temper tantrums	1	2	3	4	5	6	7	Yes	No
Sasses adults	1	2	3	4	5	6	7	Yes	No
Whines	1	2	3	4	5	6	7	Yes	No
Cries easily	1	2	3	4	5	6	7	Yes	No
Yells or screams	1	2	3	4	5	6	7	Yes	No
Hits parents	1	2	3	4	5	6	7	Yes	No
Destroys toys and/or other objects	1	2	3	4	5	6	7	Yes	No
Is careless with toys and/or other objects	1	2	3	4	5	6	7	Yes	No
Steals	1	2	3	4	5	6	7	Yes	No

	Never	Seldom	Sometimes		Often		Always		
Lies	1	2	3	4	5	6	7	Yes	No
Teases or provokes other children	1	2	3	4	5	6	7	Yes	No
Verbally fights with friends his/her own age	1	2	3	4	5	6	7	Yes	No
Verbally fights with siblings	1	2	3	4	5	6	7	Yes	No
Physically fights with friends his/her own age	1	2	3	4	5	6	7	Yes	No
Physically fights with siblings	1	2	3	4	5	6	7	Yes	No
Constantly seeks attention	1	2	3	4	5	6	7	Yes	No
Interrupts others	1	2	3	4	5	6	7	Yes	No
Is easily distracted	1	2	3	4	5	6	7	Yes	No
Has a short attention span	1	2	3	4	5	6	7	Yes	No
Fails to finish tasks or projects	1	2	3	4	5	6	7	Yes	No
Has difficulty concentrating on one thing	1	2	3	4	5	6	7	Yes	No
Is overactive, restless, and/or fidgety	1	2	3	4	5	6	7	Yes	No
Acts impulsively (speech or actions)	1	2	3	4	5	6	7	Yes	No
Has problems making friends	1	2	3	4	5	6	7	Yes	No
Has problems keeping a close friend	1	2	3	4	5	6	7	Yes	No
Bed wetting	1	2	3	4	5	6	7	Yes	No
Soiling underclothes	1	2	3	4	5	6	7	Yes	No
Repeatedly checks and rechecks things	1	2	3	4	5	6	7	Yes	No
Frequently erases work at school or home	1	2	3	4	5	6	7	Yes	No
Has rough or chapped hands	1	2	3	4	5	6	7	Yes	No
Has frequent and/or excessive fears	1	2	3	4	5	6	7	Yes	No
Has to re-read or rewrite often	1	2	3	4	5	6	7	Yes	No
Is excessively concerned about illness/disease	1	2	3	4	5	6	7	Yes	No
Frequently pulls at hair or bites fingernails	1	2	3	4	5	6	7	Yes	No
Seems sad or depressed	1	2	3	4	5	6	7	Yes	No
Seems anxious or nervous	1	2	3	4	5	6	7	Yes	No

For the following list, read each problem and check for persistence.

Problem	Persistence		
	Not a Problem	Present in Most Situations	Present in All Situations
Often fidgets with hands or feet, squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)			
Has difficulty remaining seated when required to do so			
Is easily distracted by extraneous stimuli			
Has difficulty waiting turn in games or group situations			
Often blurts out answers to questions before they have been completed			
Has difficulty following through on instructions from others (not due to oppositional behavior or failure to comprehend), i.e., fails to finish chores			
Has difficulty sustaining attention in tasks or play activities			
Often shifts from one uncompleted activity to another			
Has difficulty playing quietly			
Often talks excessively			
Often interrupts or intrudes on others, i.e., butts into other children's games			
Often does not seem to listen to what is being said to him/her			
Often loses things necessary for tasks or activities at school or home, i.e., pencils, books, assignments			
Often engages in physically dangerous activities without considering possible consequences (not for thrill-seeking), i.e. runs into the street without looking			

BIRTH AND DEVELOPMENT INFORMATION

Length of Pregnancy: _______ months, _______ weeks Birth Weight: _______ pounds, _______ ounces

Baby was: ☐ early ☐ on time ☐ late

Mother has had _____ pregnancies and _____ babies.

Did mother receive prenatal care, and if so, when? ____

____

Did mother eat well during pregnancy? ____

Did mother take vitamins, calcium, iron, etc.? ____

Did mother take any medications or drugs during the pregnancy for such problems as vomiting, excessive weight gain, swelling, high blood pressure, appetite, infections, convulsions, or headaches? If so, please provide type and name? ____

____

____

Did mother have any illnesses such as the flu, cold, kidney infection, sugar diabetes, high blood pressure, seizures, or an operation during the pregnancy? ____

____

____

Did mother have any X-rays, and if so, when? ____

Did mother smoke? If so, how much? ____

Did mother drink alcohol during the pregnancy? If so, how much? ____

Did mother use illicit drugs during the pregnancy? If so, what kind and how much? ___________________________

____

Was there any spotting or bleeding during the pregnancy? If so, when, how long, and was it treated? __________

____

____

____

Was labor induced? If so, why? ____

____

What was the length/duration of labor? ____

Were there any problems with the labor or delivery? If so, what? ____

____

____

Were forceps used during delivery? If so, why? ____

____

Was the baby delivered head first? If not, was the baby delivered feet first, buttocks first, or by Caesarian section?

____

____

Did the baby cry and breathe immediately? ______________________________

What were the baby's Apgar scores? ______________________________

Did the baby have a good suck immediately? ______________________________

Was the baby given artificial resuscitation? ______________________________

Was the baby kept in oxygen, and if so, for how long? ______________________________

Baby was delivered by: ☐ Obstetrician ☐ General Practitioner ☐ Midwife ☐ Other __________

Was the baby ever jaundiced? ______________________________

Did your baby have blue skin, nails, or lips? ______________________________

Did your baby have spasms, fits, or seizures? ______________________________

Was your baby breast fed or bottle fed? ______________________________

Were there any initial feeding problems in the first week? ______________________________

How old was the baby when discharged from the hospital? ______________________________

Did your baby have a strong cry? ______________________________

Other comments: ______________________________

____

____

____

INFANCY

Was baby a good eater? ______________________________

Were there any problems with vomiting? ______________________________

Were there any problems with colic? ______________________________

Did your baby cry excessively? ______________________________

Did your baby sleep excessively? ______________________________

Was your baby cuddly? ______________________________

Please indicate age in months or years when your child did the following:

First smile (.5-4) ______________

Rolled over front to back (.7-5) ______________

Sit up alone (5-10) ______________

Crawled (5-11) ______________

Had vocabulary of 5 words (18-30) ______________

Said 2-3 word phrases (16-30) ______________

Bladder trained (16-36) ______________

Bowel trained (16-36) ______________

Grabbed objects (3-7) ______________

Pulled up to a stand (6-12) ______________

Took 2-3 steps alone (9-12) ______________

Rode tricycle ______________

Rode bicycle ______________

Fed self with cracker ______________

Able to tie shoes ______________

Dress self (buttons, zippers & snaps) ______________

MEDICAL HISTORY

Child's pediatrician: ____

When was the last time your child was checked by his/her pediatrician/family doctor? ______________________

Results of exam? ____

____

Has your child ever been hospitalized since birth? If so, please explain.______________________

____

____

Does your child receive any medication regularly, and if so, what? ______________________

____

Please indicate with a check mark whether your child has had any of the following:

_____ Chicken Pox
_____ Diphtheria
_____ German Measles
_____ Measles
_____ Mumps
_____ Polio
_____ Roseola
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Whooping Cough
_____ Heart Murmur
_____ Heart or Lung Disease
_____ Severe/Prolonged Chest Pain
_____ Asthma
_____ Bronchitis
_____ Coughed Up Blood
_____ Hives
_____ Difficulty Breathing
_____ Nose Bleeds
_____ Pneumonia
_____ Sinusitis
_____ Tonsillitis
_____ Tuberculosis
_____ Anemia

_____ Bleeding Problems
_____ Bad Teeth
_____ Bad Hearing
_____ Earaches
_____ Draining Ears
_____ Middle Ear Infections
_____ External Ear Infections
_____ Speech Problems
_____ Squinting of the Eyes
_____ Double/Blurred Vision
_____ Discharge from the Eyes
_____ Eye Problems
_____ Allergies
_____ Allergies to Medications
_____ Eczema
_____ Hay Fever
_____ Sleeping Problems
_____ Spells or Passing Out
_____ Skin Diseases
_____ Blood in Urine
_____ Kidney Disease/Infection
_____ Problems with Urination
_____ Jaundice
_____ Fever Blisters

_____ Broken Bones (yes, describe)
____
_____ Swelling of Ankles/Legs
_____ Stomach/Abdominal Pain
_____ Vomiting
_____ Trouble with Diarrhea
_____ Trouble with Constipation
_____ Bloody or Black Stools
_____ Worms in Stools
_____ Enlarged Glands
_____ Thyroid Problems
_____ Head Injuries
_____ Severe/Prolonged Headaches
_____ Paralysis or Weakness
_____ Convulsions
_____ Poisoning
_____ Painful/Swollen Joints
_____ Burns
_____ Staring or Blank Spells
_____ Unconsciousness
_____ Unexplained High Fevers
_____ Severe Injuries
_____ Operations (yes, describe)
____

Any other comments regarding your child's medical history: ____

____

____

FAMILY MEDICAL HISTORY

Please indicate with a check mark whether anyone on either side of your family has had the following:

_____ Abnormal Sexual Development
_____ Anemia
_____ Asthma
_____ Bleeding Tendency
_____ Blindness
_____ Blood Tumors
_____ Blood in Urine
_____ Bruising Tendency
_____ Cancer
_____ Cleft Palate
_____ Cleft Lip (Harelip)
_____ Convulsions
_____ Deafness
_____ Deformities

_____ Diabetes
_____ Failure to Grow
_____ Goiter
_____ Hay Fever
_____ Headaches
_____ Heart Disease
_____ High Blood Pressure
_____ Hives
_____ Leukemia
_____ Liver Disease
_____ Mental Retardation
_____ Motor or Vocal Tics
_____ Muscle Disease
_____ Paralysis

_____ Rheumatic Fever
_____ Rheumatoid Arthritis
_____ Seizure Disorder
_____ Stomach Problems
_____ Thyroid Disease
_____ Unconscious Spells
_____ Visual Problems
_____ Alcoholism
_____ Anxiety
_____ Behavior Problems
_____ Depression
_____ Hyperactivity
_____ Poor Concentration
_____ Reading Problems

Any other comments regarding your family medical history: ____

____

____

SCHOOL HISTORY

Preschool

Did your child attend preschool? If so, at what age? ____

Could your child effectively use scissors, crayons, and pencils? ______________________________________

How well did your child get along with other children? ____

____

Any behavior problems at that time? ____

____

Any teacher comments (about behavior or school readiness)? ______________________________________

____

Was child hyperactive, very restless, or very fidgety? ____

Did child have a short attention span? ____

Was child impulsive? ____

Kindergarten

Was your child's performance: (check one) ☐ Above Average ☐ Average ☐ Below Average

How well did your child get along with other children? ______________________________

____

Any behavior problems? ______________________________

Any teacher comments? ______________________________

____

Could your child effectively use scissors, crayons, and pencils? ______________________________

Was your child hyperactive, very restless, or very fidgety? ______________________________

Did your child have a short attention span? ______________________________

Was your child impulsive? ______________________________

First Grade

At the beginning of the first grade, did your child know the alphabet? ______________________________

Numbers from 1 to 10? ______________________________

Rate your child's performance while in the first grade: ☐ Above Average ☐ Average ☐ Below Average

Could your child follow directions? ______________________________

Was your child hyperactive, very restless, or very fidgety? ______________________________

Did your child have a short attention span? ______________________________

Was your child impulsive? ______________________________

Did your child participate cooperatively in group activities? ______________________________

Any behavior problems? ______________________________

Any teacher comments? ______________________________

____

Has your child had difficulty with spelling or reading (letter reversals, word reversals, forgetting letters and words easily, difficulty learning to spell, difficulty with words beginning with "th," "wh," or "w")? ______________________________

____

____

Did you help your child with schoolwork/homework? ______________________________

____

Was your child promoted to the second grade? ______________________________

Other comments regarding your child's early elementary school experience: ______________________________

____

____

____

____

____

LATER SCHOOL HISTORY

Beginning with the **second grade,** list your child's grade placement and any comments from the teacher, as well as your own observations as to your child's educational progress and/or behavior problems. Please note if the child missed more than two weeks of school in any year due to illness, etc.

Year	Grade	Comments

Have school personnel reported any of the following about your child?

Poor Reader	☐ Yes	☐ No	☐ Don't Know
Distractible	☐ Yes	☐ No	☐ Don't Know
Inattentive	☐ Yes	☐ No	☐ Don't Know
Disturbs other children	☐ Yes	☐ No	☐ Don't Know
Does not complete work	☐ Yes	☐ No	☐ Don't Know
Excessive talking	☐ Yes	☐ No	☐ Don't Know
Daydreams	☐ Yes	☐ No	☐ Don't Know
Slow in moving/responding	☐ Yes	☐ No	☐ Don't Know
Fights	☐ Yes	☐ No	☐ Don't Know
Gets out of seat without permission	☐ Yes	☐ No	☐ Don't Know
Difficulty following instructions	☐ Yes	☐ No	☐ Don't Know
Difficulty in thinking of words to say	☐ Yes	☐ No	☐ Don't Know
Impulsive	☐ Yes	☐ No	☐ Don't Know

What is your child's attitude toward completing written assignments (essays, compositions, etc.)? ______________

____

____

Describe any tutoring aids, special classes, or special help your child has received, and indicate if it was helpful: __

____

____

____

Describe your child's attitude toward school in general: ____

____

Describe your own attitude toward the child's school: ____

____

What are your child's usual conduct grades? ____

____

Do you help your child with schoolwork/homework? ____

____

Please estimate your child's intellectual level:

☐ Very High ☐ High ☐ Average ☐ Low ☐ Very Low

READING HISTORY

What is your child's attitude toward reading? ______________________________

____

Does your child read spontaneously? If so, how much/often? ______________________________

____

Child's reading speed is generally: ☐ Fast ☐ Average ☐ Slow

Does your child have difficulty reading in public or in front of the class? ______________________________

Have you bought or borrowed any books for your child lately? ______________________________

What kinds of books does your child like to read? ______________________________

____

How often and when do you read to your child? ______________________________

____

How often do you discuss what your child reads? ______________________________

____

About how long does your child watch television on an average school day? ______________________________

____

What are your child's favorite television programs? ______________________________

____

HOME HISTORY

Please list all members of your family, including mother and father, and note the age of and the child's relationship to each family member. Also, list the grade and usual marks of all siblings.

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____

Did anyone else in the family ever have a learning or reading problem? If so, please describe. ________________

What activities, special treats, or toys would your child find rewarding? ________________

Describe a typical afterschool afternoon and evening with your child: ________________

Does your child sleep in his/her own bed at night? If not, where does your child sleep and how long has this occurred? ________________

How long does it take, from starting to get to bed to settling down into bed, for your child to get to bed at night? ________________

Does your child seem to take an unusually long time to get dressed and ready for school or other activities? If yes, please explain: ________________

What are your typical methods of discipline with your child? ________________

Describe the main differences between mother and father in the method of disciplining or the standards of conduct used: ________________

How does your child react to frustrations? ________________

Does your child participate in group activities (Scouts, sports, etc.)? ________________

Does your child have any special abilities (dance, sports, music, art, etc.)? Please describe: ________________

Mother, what activities do you enjoy doing with your child? ____
____
____

Father, what activities do you enjoy doing with your child? ____
____
____

Has your child previously been given psychological, speech, and/or hearing evaluations? If so, please give the name and phone number of the person who performed the evaluation(s). __________________________________
____
____
____

Have you or your family ever sought counseling? If so, when? ____
____
____
____

With whom did you seek counseling? What was the precipitating problem? _________________________________
____
____
____

Please note any additional comments here: ____
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____
____
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____

Please complete this form to the best of your knowledge.

Age	Health and Development (infections, fevers, accidents, etc.)	Siblings (born/adopted)	Family Changes (Death, divorce, moves, severe illness, etc.)	School Name/City/Grade (include nursery school and kindergarten)	Comments about child's attitude, etc.
0					
1					
2					
3					
4					
5					
6					
7					
8					
9					

Age	**Health and Development (infections, fevers, accidents, etc.)**	**Siblings (born/adopted)**	**Family Changes (Death, divorce, moves, severe illness, etc.)**	**School Name/City/Grade (include nursery school and kindergarten)**	**Comments about child's attitude, etc.**
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					

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