ALL ABOUT KIDS Pediatrics, Inc.

Pre-visit Parent Questionnaire: Evaluation of Academic/Behavior Concerns

Name of Child: _____ Date of Birth: _____

Date completed: _____ Completed by: _____ Relationship to child: _____

CONCERNS:
Briefly list concerns (academic, behavioral, social, or emotional) about your child. Rank priority first.

At what age did your child first have these problems? _____

Check areas of your child's life most impacted by these concerns: ☐ School ☐ Home ☐ Social ☐ Activities

STRENGTHS:
Please list your child's strengths, abilities, accomplishments:

FAMILY INFORMATION:
Primary Household:

- Parent / Guardian: Name: _____ DOB: _____
  Relationship to Patient: _____ Job: _____
- Parent / Guardian: Name: _____ DOB: _____
  Relationship to Patient: _____ Job: _____
- Siblings? (names, ages) _____
- Other adults/children living at home? (names, relationships to child):
  _____

Secondary Household: ☐ Yes ☐ No

- Parent / Guardian: Name: _____ DOB: _____
  Relationship to Patient: _____ Job: _____
- Parent / Guardian: Name: _____ DOB: _____
  Relationship to Patient: _____ Job: _____
- Siblings? (names, ages) _____
- Other adults/children living at home? (names, relationships to child):
  _____

Do any of the following apply to your child's living situation?

- Does your child's behavior cause significant stress in the home? ☐ Yes ☐ No
- Recent major changes or stresses in the child's family or home life? ☐ Yes ☐ No
- Significant conflict with siblings or others living in the home? ☐ Yes ☐ No
- Marital problems between parents or caregivers? ☐ Yes ☐ No
- Alcohol or drug problems in the home? ☐ Yes ☐ No
- Domestic violence in the home? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Pregnancy and Birth:

1. Any difficulties with pregnancy? _____
2. Did mother use any of the following during pregnancy?
   - Cigarettes/Vaping: ☐ Yes ☐ No
   - Alcohol: ☐ Yes ☐ No
   - Street drugs: ☐ Yes ☐ No
   - Prescribed medicine(s): ☐ Yes ☐ No
3. Where was child born? _____
4. Was it a difficult delivery? ☐ Yes ☐ No
   - Did your baby need oxygen? ☐ Yes ☐ No
   - Vigorous Resuscitation? ☐ Yes ☐ No
   - Prolonged hospitalization after birth? ☐ Yes ☐ No
5. Birth weight _____lb _____oz
6. Premature birth? ☐ Yes ☐ No How early? _____ weeks gestation

Major Illnesses:

1. Seizures? ☐ Yes ☐ No Type _____ Treatment _____
2. Heart Problems? ☐ Yes ☐ No Type _____ Treatment _____
3. Other: _____

Current Medications: _____

Hospitalizations: ☐ Yes ☐ No (if yes, explain) _____

Surgeries: ☐ Yes ☐ No (if yes, explain) _____

Serious Injuries:

1. Head injuries? ☐ Yes ☐ No How many? _____ What age(s)? _____
2. Poison ingestions? ☐ Yes ☐ No Name of poison(s): _____ What age(s)? _____
3. History of physical, emotional, sexual abuse? ☐ Yes ☐ No Neglect? ☐ Yes ☐ No
   (If yes explain) _____

DEVELOPMENTAL HISTORY:

Did/does your child have delays in the following areas?

Big muscle development?

- Late sitting up (after 8 months)? ☐ Yes ☐ No
- Late walking (after 15 months)? ☐ Yes ☐ No

Coordination?

- Problems throwing/catching ball? ☐ Yes ☐ No
- Problems running/jumping? ☐ Yes ☐ No
- Problems riding a bicycle? ☐ Yes ☐ No

Fine motor skills?

- Problems tying shoes? ☐ Yes ☐ No
- Problems coloring in the lines? ☐ Yes ☐ No
- Problems using scissors? ☐ Yes ☐ No
- Problems with handwriting? ☐ Yes ☐ No
- Difficult to read handwriting? ☐ Yes ☐ No

Language development?

- Late single words (after 18 mo.)? ☐ Yes ☐ No
- Late phrases (after 2 years)? ☐ Yes ☐ No
- Late sentences (after 3 years)? ☐ Yes ☐ No
- Understanding language? ☐ Yes ☐ No
- Social aspects of language? ☐ Yes ☐ No

ADHD History: ☐ Yes ☐ No

When diagnosed? (age/grade) _____ Who made the diagnosis? _____

Learning Disability: ☐ Yes ☐ No

What Type(s)? ☐ Reading / Dyslexia ☐ Writing / Dysgraphia ☐ Math / Dyscalculia ☐ Auditory Processing

When diagnosed? (age/grade) _____ Who made the diagnosis? _____

Mealtime problems:

- Dietary restrictions? ☐Yes ☐No
- *Specify* _____
- Picky eater? ☐Yes ☐No
- Feeding causes stress for parent? ☐Yes ☐No
- Difficulty sitting through meals? ☐Yes ☐No
- Needs distraction (e.g. TV) to eat? ☐Yes ☐No

Elimination problems:

- Late in toilet training? ☐Yes ☐No
- Late in staying dry at night? ☐Yes ☐No
- Accidents after trained? ☐Yes ☐No
- Constipated? ☐Yes ☐No

Sleep problems:

- Trouble falling asleep? ☐Yes ☐No
- Trouble sleeping alone? ☐Yes ☐No
- Trouble staying asleep? ☐Yes ☐No
- Restless sleep? ☐Yes ☐No
- Snoring or mouth breathing? ☐Yes ☐No
- Hard to awaken? ☐Yes ☐No

Struggles with Routines:

Problems leaving the house in AM? ☐Yes ☐No

- Needs reminders? ☐Yes ☐No
- Gets distracted? ☐Yes ☐No
- Late unless prodded? ☐Yes ☐No
- Forgets steps of routine? ☐Yes ☐No

Problems with bedtime? ☐Yes ☐No

- Resists going to bed? ☐Yes ☐No
- Electronics in bedroom? ☐Yes ☐No
- Electronics w/in 1hr of bedtime? ☐Yes ☐No
- Forgets steps of routine? ☐Yes ☐No

SCHOOL:

1. Academic:

- Is your child below grade level? ☐Yes ☐No If yes, by how much? _____
- Does teacher raise concerns about progress? ☐Yes ☐No
- Struggles or gets extra help in:
  Reading? ☐Yes ☐No Math? ☐Yes ☐No Writing? ☐Yes ☐No

What contributes to learning difficulties?

- Not paying attention in class ☐Yes ☐No
- Not finishing all homework ☐Yes ☐No
- Homework late or lost ☐Yes ☐No
- Does not study for tests ☐Yes ☐No
- Rushed, careless, not proofread ☐Yes ☐No
- Does not understand material ☐Yes ☐No

2. Behavior:

- Ignores or disobeys rules? ☐Yes ☐No
- Disrupts classroom? ☐Yes ☐No
- Can't sit still? ☐Yes ☐No
- Disrupts other children? ☐Yes ☐No

Does your child have an IEP or 504 Plan? ☐Yes ☐No If yes, ☐IEP or ☐504?
If yes, please list accommodations and/or pull-out services:

SOCIAL:

- Few or no friends? ☐Yes ☐No
- Few party invites/playdates? ☐Yes ☐No
- Prefers younger/older kids? ☐Yes ☐No
- Immature compared to peers? ☐Yes ☐No
- Does not have one good friend? ☐Yes ☐No
- Makes friends but loses them? ☐Yes ☐No
- Doesn't read social cues? ☐Yes ☐No
- "In your face"? ☐Yes ☐No
- Inappropriate touching? ☐Yes ☐No
- Competitive or needs to win? ☐Yes ☐No

If problems with peer relationships, what behaviors get in the way of success?

_____

INTERESTS & ACTIVITIES: _____

MEDIA USE: _____

EXECUTIVE FUNCTION:

Focus and Distractibility:

- Inattentive in non-school activities? ☐Yes ☐No
  - During chores? ☐Yes ☐No
  - Getting dressed? ☐Yes ☐No
- Problems with transitions? ☐Yes ☐No
  - Hard to stop current activity? ☐Yes ☐No
  - Change in usual day/week? ☐Yes ☐No
- Does your child daydream a lot? ☐Yes ☐No
- Difficulty with multiple instruction? ☐Yes ☐No
- Distracted easily during homework? ☐Yes ☐No
  - Gets up and down? ☐Yes ☐No
  - Needs 1:1 to stay on task? ☐Yes ☐No
  - Takes long time to finish work? ☐Yes ☐No

Activation:

- Appears unmotivated to work? ☐Yes ☐No
- Procrastinates with non-preferred tasks?
  - Homework: ☐Yes ☐No
  - Chores: ☐Yes ☐No

Effort:

- Hard to sustain effort on some tasks? ☐Yes ☐No
- Easily frustrated? ☐Yes ☐No
- Gives up easily or "shuts down"? ☐Yes ☐No

Memory:

- Short-term memory problems? ☐Yes ☐No
  - Loses and misplaces things? ☐Yes ☐No
  - Forgets things at school? ☐Yes ☐No
- Doesn't learn from experience? ☐Yes ☐No
- Forgets to turn in homework? ☐Yes ☐No
- Trouble remembering schoolwork? ☐Yes ☐No

Emotion:

- Has big reactions to small triggers? ☐Yes ☐No
- Has "meltdowns"? ☐Yes ☐No
- Has anger problems? ☐Yes ☐No
- Hitting or fighting? ☐Yes ☐No
- Breaking or throwing objects? ☐Yes ☐No
- Destroying property? ☐Yes ☐No

Activity/Impulsivity:

- Hyperactive? ☐Yes ☐No
- Fidgety or wiggly? ☐Yes ☐No
- Does your child talk excessively? ☐Yes ☐No
- Can't sit quietly and watch TV? ☐Yes ☐No
- Makes impulsive statements? ☐Yes ☐No
  - Problems interrupting? ☐Yes ☐No
  - Problems blurting out? ☐Yes ☐No
- You avoid restaurants with your child? ☐Yes ☐No
- You avoid shopping with your child? ☐Yes ☐No

ADDITIONAL CONCERNS:

Self-esteem:

- Your child has poor self-esteem? ☐Yes ☐No
- Makes self-derogatory statements? ☐Yes ☐No

Mood:

- Child acts sad or down? ☐Yes ☐No
- Child acts irritable/angry often? ☐Yes ☐No
- Child has been withdrawn? ☐Yes ☐No
- Not interested in things they enjoy? ☐Yes ☐No
- Recent change in appetite? ☐Yes ☐No
- Recent change in sleep? ☐Yes ☐No
- Child has weeks of being super happy, energetic, more confident than usual? ☐Yes ☐No
- Do any of the above cause problems with family, friends, or school? ☐Yes ☐No

Anxiety:

- Child has excessive worries/fears? ☐Yes ☐No
- Has frequent headaches? ☐Yes ☐No
- Has frequent stomach aches? ☐Yes ☐No
- Has panic attacks? ☐Yes ☐No
- Tries to avoid going to school? ☐Yes ☐No
- Hates school? ☐Yes ☐No
- Has difficulty meeting new people? ☐Yes ☐No
- Has trouble leaving parents? ☐Yes ☐No
- Must check/clean/organize to feel OK? ☐Yes ☐No
- Gets “stuck on thoughts”? ☐Yes ☐No
- Has excessive fear of germs? ☐Yes ☐No
- Do any of the above cause problems with family, friends, or school? ☐Yes ☐No

Oppositional or defiant behaviors:

- Problems with obedience/compliance? ☐Yes ☐No
  - Argumentative? ☐Yes ☐No
  - Oppositional or defiant? ☐Yes ☐No
  - Blames others? ☐Yes ☐No
- Does your child lie? ☐Yes ☐No
  - Refuses to admit responsibility? ☐Yes ☐No
  - Makes up untrue stories? ☐Yes ☐No
- Any association with a gang? ☐Yes ☐No
- Does your child steal? ☐Yes ☐No
  - Money from home/others’ toys? ☐Yes ☐No
- Ever been involved in antisocial behavior:
  - Setting fires? ☐Yes ☐No
  - Breaking and entering? ☐Yes ☐No
  - Physical violence with weapon? ☐Yes ☐No
  - Cruelty to animals or peers? ☐Yes ☐No
- Contact with police/juvenile authority? ☐Yes ☐No

Communication / Regulation:

- Trouble reading social cues/facial expression/body language? ☐Yes ☐No
- Problems with peer relationships? ☐Yes ☐No
- Intensely focused on a limited number of interests? ☐Yes ☐No
- Sensory issues (sound, touch, smell, texture, picky eater)? ☐Yes ☐No
- Repetitive behaviors (hand flapping, repeating phrases) or speech? ☐Yes ☐No
- Insist on special routines and upset if not followed? ☐Yes ☐No

Tics:

- Does your child have a muscle tic? ☐Yes ☐No
- Make repetitive vocal noises? ☐Yes ☐No

Substance Abuse:

- Ever got in trouble for using:
  - Nicotine / Vaping? ☐Yes ☐No
  - Alcohol? ☐Yes ☐No
- Ever use marijuana? ☐Yes ☐No
- Other illicit drugs? ☐Yes ☐No
- Ever been in rehab? ☐Yes ☐No
  - If yes, When? For what substance?
  - _____

INTERVENTIONS: What have you already done to try to help?

Prior evaluation(s) _____

Tutoring _____

Counseling _____

Parent Supports _____

Therapies _____

- Occupational therapy (OT) ☐Yes ☐No
- Physical therapy (PT) ☐Yes ☐No
- Speech therapy ☐Yes ☐No
- Social skills ☐Yes ☐No

Other _____

Medication Details (if applicable):

- Names / dose/ dates taken: _____
- Side effects? _____
- Why stopped? _____ When stopped?_____

Discipline techniques that are helpful:

- Time-outs? ☐Yes ☐No
- Consequence system? ☐Yes ☐No
- Reward system? ☐Yes ☐No
- Restriction of privileges? ☐Yes ☐No
- Nothing works? ☐Yes ☐No
- Other? _____

FAMILY HISTORY: List person affected and relationship to child.

- ADHD: ☐Yes ☐No _____
- Learning disability: ☐Yes ☐No _____
- Anxiety/OCD: ☐Yes ☐No _____
- Depression: ☐Yes ☐No _____
- Bipolar: ☐Yes ☐No _____
- Autism: ☐Yes ☐No _____
- Abnormal heart rhythm? ☐Yes ☐No Needed a pacemaker? ☐Yes ☐No _____
- Substance abuse: ☐Yes ☐No _____
- Trouble with the law: ☐Yes ☐No _____

GOALS:

What do you want to see happen for your child?

1. _____
2. _____
3. _____
4. _____
5. _____