PRESCHOOL Parent Questionnaire

Thank you so much for taking the time to fill out this form. This is a generic form, so some of the information will not apply to your child. However, please fill it out as completely as possible. You play a critical role in your child's development and getting a complete medical and social history is a crucial part in the evaluation process. The pertinent information on this form will be included in the evaluation report; however, this form and the report remain confidential and remain in your child's secured clinical file. This information can only be released to others with your written permission.

Child's Name:_____ **Grade:** _____ **Date:** _____
First Middle Last

Address:_____ **School:** _____
_____ **Teacher:** _____

Phone(s):_____ **Parent(s) Email:**_____

Child's Birthdate: _____ **Age:** _____

Parents/Guardian: _____

Person filling out this form: _____

Pediatrician Name _____ **Phone:** _____

Referring Professional: _____ **Phone:** _____
Fax: _____

Has prescription been given by MD? __Yes __ No
Does your child have an allergy to latex? __Yes __ No

Presenting Problem:

Please explain your primary concerns for referring this child (concerns, difficulties, questions):

_____
_____
_____
_____

How have these difficulties improved or deteriorated? _____
_____
_____

Does anything alleviate some of the problems or concerns this child experiences?
_____

Is there anything that makes the problems or concerns worse?
_____

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.

Down's Syndrome _____
Fragile X Chromosome _____
Cancer _____
Cystic Fibrosis _____
Diabetes _____
Hypoglycemia _____
Food allergies _____
Atmospheric Allergies _____
Multiple sclerosis _____
Muscular dystrophy _____
Seizures or epilepsy _____
Nervousness/ Anxiety_____
Tourette's Disorder _____
Asperger's Syndrome_____
Neurofibromatosis_____
Pervasive Development Disorder _____
Speech or language problem_____
Attention Deficit Disorder _____
Depression _____
Mental Illness (e.g. Bipolar Disorder, Manic Depression, Mania, Schizophrenia, Obsessive Compulsive Disorder) _____
Other: Describe _____

Learning Problems-
Reading of Words _____
Reading Comprehension _____
Spelling _____
Math Computation _____
Math Concepts _____
Handwriting _____
Written Expression _____
Oral Expression _____
Listening Comprehension _____

Preconception

Prior to conception, were any substances (prescription medication and/or non-prescription drugs (including illicit drugs) used by the mother or father? If reluctant to write this down, please share them verbally with the evaluator. _____

_____

Pregnancy

Check any of the following complications that occurred during the pregnancy

Difficulty conceiving _____ Toxemia ____ Abnormal weight gain ____
Measles ____ Excessive vomiting ____ German measles ____
Excessive swelling ____ Emotional problems ____ Vaginal bleeding ____
Flu ____ Anemia ____ High blood pressure _____
Other_____
Hospitalization during pregnancy: Reason_____

Alcohol or Cigarettes used during pregnancy: ___ Yes ___ No If Yes, Frequency? _____
Other drugs used during pregnancy:

Type and Frequency	Prescription?	
_____	____Yes	____No
_____	____Yes	____No
_____	____Yes	____No
Was the child very active in utero?	____Yes	____No

Birth

Was this child born in a hospital? ____Yes ____No
Was the baby: _____ Premature: How premature? _____
_____ Late: How late? _____
_____ Full Term
Length of labor: _____ Hours _____ Don't know
Birth weight _____lbs. _____oz.
Apgar score at birth _____at 5 min. _____ Don't know
Child's condition at birth _____
Mother's condition at birth _____

Check any of the following complications that occurred during birth
Breech birth _____ Labor induced Vacuum _____ Cesarean delivery _____
Forceps _____Position of forceps _____
Other complications during delivery: Describe _____
_____
Neonatal care: Explain _____
_____
Jaundiced: Bilirubin Count (Check One) ____Very High ____High ____ Just Above___ Normal
Bilirubin lights? ____Yes ____No
Breathing problems right after birth: ____ Yes ____ No Describe _____
Supplemental oxygen? ____Yes ____ No How long _____

Child had illnesses and/or Disease; ____Yes ____ No
Describe _____
Length of stay in the hospital: Mother: _____days Child: _____days
If the baby did not come home from the hospital with the mother, why?
_____
_____
Did the child have eating problems? _____ No _____ Yes Explain: _____
Which of the following best describes the child as an infant?

_____ Fun	_____ Quiet	_____ Sickly
_____ Fussy	_____ Irritating	_____ Overactive

Early Development

At what age did this child first do the following? *Please indicate approximate month and/or year of age*

_____Sit alone
_____Crawl
_____Stand alone
_____Walk alone
_____Combine two words
_____ Show interest in or attraction to sound
_____ Speak first words
_____ Speak in sentences

When was this child toilet trained? Days: _____ Nights: _____
Did bed-wetting or soiling occur after toilet training? ____Yes ___ No If yes, until what age? ___
Were there any medical reasons for the bed wetting or soiling? ____Yes ____ No
If yes, please describe _____
Has the child experienced any of the following problems? ____Yes ____ No If yes, please describe.
Chronic ear infections ____Yes ____ No ___
Age of onset _____ Frequency _____
Tubes? ____Yes ____ No Still Occurring? ____Yes ____ No
Adenoids removed? ____Yes ____ No
Tonsils removed? ____Yes ____ No Wear hearing aid? ____Yes ____ No
Hearing Loss? ____Yes ____ No
Wear eyeglasses? ____Yes ____ No

Which hand does this child use for writing or drawing? _____
For Eating _____ For Throwing, Catching, etc. _____
During his/her Preschool/Kindergarten years:
How well did the child cut?
Poor ____ Fair ____ Good ____ Excellent ____
How well did the child color in the lines?
Poor ____ Fair ____ Good ____ Excellent ____

Later Development

From the age of 5 to the present time, were/are any special problems 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 directions ____Yes ____ No _____
Difficulty following multiple directions ____Yes ____ No _____
Difficulty articulating sounds, if so which sounds ____Yes ____ No _____
Difficulty discriminating words that sound similar ____Yes ____ No _____
Does/Did child often misspeak or substitute similar sounding words? ____Yes ____ No _____
Difficulty telling a story in sequence ____Yes ____ No _____
Do others generally understand your child when he/she speaks? ____Yes ____ No

Does your child ever sound like he/she is stuttering? ____Yes ____ No
Does your child's voice ever sound hoarse? ____Yes ____ No
Do others tease your child about his/her speech? ____Yes ____ No
Does your child ever seem confused by what you say? ____Yes ____ No
Does your child have difficulty following directions? ____Yes ____ No
Are there currently, or have there been in the past, any feeding problems with your child? (e.g. problems with sucking, swallowing, drooling, chewing, etc.) ____Yes ____ No
If yes, describe _____

Is your child a picky eater, who avoids certain textures of food? (e.g. mushy, crunchy, chewy, etc.)
____Yes ____ No If yes, which textures does your child refuse? _____

Medical History

Has the child had any of the following:
Serious accidents ____ No ____ Yes At what age? ____ Specify: _____
Serious illnesses ____ No ____ Yes At what age? ____ Specify: _____
Head injury: Describe-occurrence and location on skull ____Yes ____ No
_____
Coma or loss of consciousness: Describe _____
Seizure(s): Describe _____
Has this child ever taken medication for an Attention Deficit Disorder? ____Yes ____ No

If yes, what medication? _____ Dosage? _____

Are there any other factors, which could have caused insult to this child's central nervous system?
____Yes ____ No _____

Please indicate whether this child currently has any of the following problems.
If yes, describe how often.
Frequent colds ____Yes ____ No ____ _____
Chronic cough ____Yes ____ No ____ _____
Sinus condition ____Yes ____ No ____ _____
Shortness of breath or dizziness with physical exertion ____Yes ____ No
Heart condition ____Yes ____ No _____
Autism ____Yes ____ No _____
Compulsive behaviors ____Yes ____ No _____
Pervasive Development Disorder ____Yes ____ No _____
Nonverbal Learning Disorder ____Yes ____ No _____
Sensory Processing Disorder ____Yes ____ No _____
Other Neurological Condition ____Yes ____ No _____

Friendships *Please indicate how this child relates to other children*
Has problems relating to or playing with other children? ____Yes ____ No
If yes, describe _____

Prefers playing with younger children? ____Yes ____ No _____

Has difficulty making friends? ____Yes ____ No _____

Prefers to play alone? ____Yes ____ No _____

What role does this child take in peer group games, (i.e., leader, aggressor, follower, etc.)?

_____

Recreation/Interests

What activities does this child enjoy?

Sports: _____

Hobbies: _____

Other: _____

Daily Routines

Please provide a detailed description of your child's daily routine. Consider sleep times (including naps), meals, snacks, school schedule, extra-curricular activities, etc.

6:00 am _____

7:00 am _____

8:00 am _____

9:00 am _____

10:00 am _____

11:00 am _____

12:00 pm _____

1:00 pm _____

2:00 pm _____

3:00 pm _____

4:00 pm _____

5:00 pm _____

6:00 pm _____

7:00 pm _____

8:00 pm _____

9:00 pm _____

Please list your child's typical food choices throughout the day.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Has the child ever had an occupational therapy evaluation? ____Yes ____ No

If yes, therapist's name: _____

When? _____

Has this child ever had psychological counseling and/or exam? ____Yes ____ No
If yes, psychiatrist or psychologist's name _____
When? _____

Has this child ever had a neurological exam? ____Yes ____ No
If yes, Neurologist's name _____
Date of exam _____
Reason for exam _____
_____

Has this child ever had a physical therapy exam? ____Yes ____ No
If yes, therapist's name _____
Date of exam _____
Reason for exam _____
_____

Has this child ever had a speech/language therapy exam? ____Yes ____ No
If yes, therapist's name _____
Date of exam _____
Reason for exam _____
_____

Has this child ever had an optometric exam? ____Yes ____ No
If yes, optometric physician's name_____
Date of exam _____
Reason for exam _____
_____

Has this child ever had an audiological / hearing exam? ____Yes ____ No
If yes Audiologist's name _____
Date of exam _____
Reason for exam _____

Signature below acknowledgement of the Notice of our Privacy Practices (view online):

Print Name: _____

Signature_____ Date: _____

Child's Name: _____ Date: _____

SENSORY CHECKLIST (For Parents)

Place a check in the appropriate column. Feel free to make other comments you feel are pertinent to your child's sensory development.

TACTILE SENSATION: Does your child:
____ Object to being touched or cuddled?
____ Was your child irritable in infancy, particularly when held?
____ Prefer to touch rather than be touched?
____ Dislike having hair and/or face washed?
____ Prefer certain textures of clothing?
____ Avoid certain textures of food?
____ Isolate self from other children?
____ Frequently bump or push other children?

VESTIBULAR SENSATION Does your child:
____ Seem fearful in space? (going up/down stairs riding, teeter totter, etc)
____ Appear clumsy, often bumping into things or falling down?
____ Prefer fast-moving, spinning carnival rides?
____ Appear to be in "perpetual motion"? Difficulty sitting still or focusing?
____ Become easily car, air, boat sick?

MODULATION Does your child:
____ Have difficulty with transitions?
____ Shut down or have frequent meltdowns?
____ Seem to be emotionally "up and down"?
____ Have a low frustration tolerance?
____ Rock, bang head, hit easily when frustrated?

COORDINATION Does your child:
____ Manipulate small objects easily?
____ Seem accident prone?
____ Eat in a sloppy manner?
____ Have difficulty with pencil activities?
____ Have difficulty dressing and/or fastening clothes?

AUDITORY SENSATION Does your child:
____ Seem overly sensitive to sound?
____ Miss some sounds?
____ Seem confused about the direction of sounds?
____ Like to make loud noises?
____ Have a diagnosed hearing loss?

VISUAL SENSATION Does your child:
____ Have a diagnosed visual deficit?
____ Make reversals when copying?
____ Have difficulty eye-tracking?
____ Appear sensitive to light?
____ Resist having vision occluded?
____ Become excited when confronted with visual stimulation?

MUSCLE TONE: Does your child:
____ Have a diagnosed muscle pathology? (spasticity, flaccidity, rigidity, etc)
____ Seem weaker or stronger than normal? (circle one)
____ Have a weak grasp?
____ Tire easily?
____ Seem stronger than normal?

VISUAL SYMPTOM CHECKLIST- *Pre School (age 3-5)*

Place a check in the appropriate column. Feel free to make other comments you feel are pertinent to your 3-5 year old's visual development. ***(Dr. Linda Azwell, O.D. 10/2003)***

APPEARANCE

____ Frequently reddened eyes or eyelids
____ Frequently squints to see
____ Frequent watering of eyes
____ Frequent blinking of eyes
____ Eyes that sometimes appear to misalign or turn
____ Gets too close to book or paper
____ Gets too close to TV or computer
____ Covers or closes one eye when coloring or watching TV
____ Turns head to one side or tilts head unusually to view objects

ACTIVITIES

____ Avoids near visual activities like drawing or coloring
____ Shows little interest in writing, coloring, drawing
____ Short attention span for TV, computer, books
____ Avoids reading books with parent
____ Difficulty recognizing or remembering letters, numbers, words

FATIGUE

____ Has interest but tires quickly when looking at books or reading with parent
____ Has interest but tires quickly when watching TV
____ Has interest but tires quickly when using computer
____ Has interest but tires quickly when writing, coloring, drawing

SPATIAL DIFFICULTIES

____ Difficulty with eye-hand coordination for age
____ Difficulty with writing, coloring or drawing
____ Tips, bumps into things or falls often
____ Frequently knocks things over at dinner table or when playing
____ Cannot find things that are pointed to
____ Difficulty hitting, catching, or kicking ball
____ Seems generally clumsy or uncoordinated for age
____ Difficulty with balance and balance activities

DISCOMFORT/COMPLAINTS

____ Frequent eye rubbin, especially after computer or other visual tasks
____ Complains of headaches
____ Eyes frequently itch
____ Very light sensitive indoors
____ Very light sensitive outdoors
____ Easily car or motion sick, especially when reading or doing other near activity
____ Complains of blur at distance or at near
____ Complains of double vision at distance or at near

FISHER'S AUDITORY CHECKLIST

Place a check mark before each item that is considered to be a concern.
**** Leave blank if it does not apply.**

____ Has a history of hearing loss

____ Has a history of ear infections

____ Does not pay attention to instruction 50% or more of the time

____ Does not listen carefully to directions- often necessary to repeat instructions

____ Says "huh?" and "what?" at least four or more times per day

____ Cannot attend to auditory stimuli for more than a few seconds

____ Has a short attention span for auditory information

__ 0-2 mins __ 2-5 mins __5-15 mins __15-30 mins

____ Is easily distracted by background noise

____ Daydreams- attention drifts- not "with it" at times

____ Has difficulty with phonics

____ Experiences problems with sound discrimination

____ Forgets what is said in a few minutes

____ Does not remember simple routine things from day to day

____ Displays problems recalling what was heard last week, month, year

____ Has difficulty recalling a sequence that has been heard

____ Experiences difficulty following auditory directions

____ Frequently misunderstands what is said

____ Does not comprehend many words or verbal concepts for age/grade level

____ Learns poorly through the auditory channel

____ Has a language problem (morphology, syntax, vocabulary, phonology)

____ Has an articulation problem

____ Cannot always relate what is heard to what is seen

____ Lacks motivation to learn

____ Displays slow or delayed response to verbal stimuli

Authorization to Release Information

I, _____, parent of _____, whose date of birth is _____, give permission to the clinicians of Whole Child Integrative Center, LLC, to exchange information via phone, email*, or in person with the following parties: (may include physicians, psychologists, teachers, therapists, etc). If my child is seen on a school-campus, it is understood that therapists of Whole Child Integrative Center, LLC, may speak with teachers and administrators about my child as it relates to school performance. If my child is under the care of Learning Specialists from Engage the Brain, I am aware that a collaborative approach will be taken in order to enhance my child's progress.

NAME	PHONE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The information included in the release is:

_____ Initial Report
_____ Progress Notes
_____ Plan of Care
_____ Re-Evaluation
_____ Home Programming
_____ Other: (Please Specify)

*If your child is under the care of multiple therapists, the application "Google Drive" may be used to communicate with such clinicians. This would be no different than emailing however it involves sharing a file or files with the said clinician(s) in order to better keep track of information. This is all done via email sharing but is saved in the Google Drive file rather than on a hard-drive on the computers. This allows for easier access to information and ease in communication.

_____ _____

Parent/Guardian Date