



Specialist Care for Every Child

Child and Adolescent Clinic
www.CandAC.com

Parent Questionnaire
Patient's Health and Behavior History
Please Use Black Ink

Child's Name _____ Date _____

Birthdate: _____ Age _____ Sex _____

Please answer the questions by circling YES or NO. If there is a YES answer please describe in more detail. If there is neither a YES or NO answer please respond to the question with a descriptive reply.

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|--|-----|----|
| 1. Does your child have problems getting ready for school? | YES | NO |
| 2. Does your child have difficulty sitting through meals? | YES | NO |
| 3. Does your child have difficulty sitting quietly to watch TV? | YES | NO |
| 4. Does your child have difficulty sleeping? | YES | NO |
| 5. Does your son (or daughter) have motor or vocal tics? | YES | NO |
| 6. Does anyone in the family have ADHD or learning problems? | YES | NO |
| 7. Did your child have problems in preschool? | YES | NO |
| 8. Does your child have problems with gross or fine motor skills? | YES | NO |
| 9. Is your child's handwriting difficult to read? | YES | NO |
| 10. Is your child the "class clown?" | YES | NO |
| 11. Is your child distractible when doing schoolwork? | YES | NO |
| 12. Is your child distractible when playing? | YES | NO |
| 13. Does your child's performance fail to improve with one-on-one help? | YES | NO |
| 14. Is the child's performance inconsistent? | YES | NO |
| 15. Does your child have problems following three or more instructions delivered at the same time? | YES | NO |
| 16. Does your child make impulsive statements? | YES | NO |
| 17. Is your child a "daredevil?" | YES | NO |
| 18. Does your child play with fire and matches? | YES | NO |
| 19. Does your child have trouble controlling anger? | YES | NO |
| 20. Does your child have trouble making friends? | YES | NO |
| 21. Is your child immature compared with peers? | YES | NO |
| 22. Does your child disobey you? | YES | NO |

Patient's Name: _____

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|---|-----|----|
| 23. Does the child lie? | YES | NO |
| 24. Does the child steal? | YES | NO |
| 25. Does the child have trouble consistently following rules? | YES | NO |
| 26. Does the child have trouble sharing? | YES | NO |
| 27. Would you describe your child as "high-maintenance"? | YES | NO |
| 28. During your pregnancy was this child more active than his/her siblings? | YES | NO |
| 29. During your pregnancy with this child, did you smoke? | YES | NO |
| 30. During your pregnancy with this child, did you drink? | YES | NO |
| 31. During your pregnancy with this child, did you use recreational drugs? | YES | NO |
| 32. Was your child's birth weight low? | YES | NO |
| 33. Was your child colicky as an infant? | YES | NO |
| 34. Does your child have a history of accidents and injuries? | YES | NO |
| 35. Has your child had a serious illness or injury? | YES | NO |

TOTAL

36. How would you describe your child's self-esteem? _____

37. How would you describe your child's social skills? _____

38. What other impulsive behavior does your child exhibit? _____

39. How good is your child's memory? _____

40. How are your child's organizational skills? _____

41. What are your child's most attractive traits? _____

42. What does your child enjoy playing with? _____

43. What are your child's greatest talents? _____

44. How does your child react to changes in schedule? _____
