RUSH NEUROBEHAVIORAL CENTER

4711 Golf Rd., Suite 1100
Skokie, IL 60076

(847) 933-9339
http://rnbc.org

Please attach a recent picture of your child here.

Parent Questionnaire

Date: ___________________

Person completing this form

Name: __________________________________ Relationship to Child: ____________________________

INFORMATION ABOUT YOUR CHILD

Child's Name: ____
(Last) (First) (Middle)

Child's Date of Birth: _________Child's Age: ____________Child's Gender: (please circle) F M

Child's Current Address: ____

____

Home Phone #: _______________________

School:___________________________________ Child's Grade: ______________

Child's Ethnicity: African American Asian Caucasian Hispanic Other (specify):

Household location (check one): Urban ____Suburban______ Rural_____

Language spoken at home: English: _________Other: _________

Is child adopted? No Yes, If yes, at what age?

From where?________________________

PARENT/CAREGIVER INFORMATION

Biological Mother: ____ DOB: __________________
Education: ______________________________________Occupation: ______________
Other phone numbers: ____
Email: ____

Biological Father: ____DOB: __________________
Education: ______________________________________Occupation: _____________
Other phone numbers: ____
Email: ____

Adopted/Step/Foster Parent: ________________________DOB: ____________
Education: _____________________________________Occupation: ____________
Other phone numbers: ____
Email: ____

Adopted/Step/Foster Parent: ________________________DOB: ____________
Education: _____________________________________Occupation: ____________
Other phone numbers: ____
Email: ____

Please indicate the names of other child care providers and the length of time they provide care for your child:

Care Provider ____________ Age of Child _______ Length of time ________________________________
Care Provider _____________Age of Child ________Length of time ________________________________

Is child currently living with both parents? No___ Yes___ If no, with which parent is the child living now?
Father ______Mother ______ Other (specify): ______________

Who has full legal and medical custody of the child: ____
(Please bring to your first meeting a child custody decree or other proof of custody.)

Marital status of the primary caregiver(s):

___ Single ___ Separated; How long __________

___ Married ___ Divorced; Date of divorce ______

___ Cohabitating

REFERRAL INFORMATION

Who referred you to our service?

Name: __________________________ Profession: _____________________________

Address: _________________________

Phone Number: ___________________

PRESENTING CONCERNS

A. What questions do you hope can be answered in this evaluation?

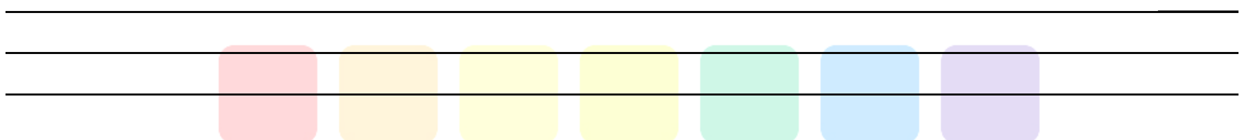
1. ____
2. ____
3. ____
4. ____

B. What concerns do you have about your child and why are you seeking help for your child at this time?

C. What kind of information or assistance are you hoping to obtain for your child? In school, at home, etc.?

D. Does your child have any school behavior problems? ☐ Yes ☐ No If yes, please describe:

E. Does your child have any studying and/or learning problems? ☐ Yes ☐ No If yes, please describe:



F. When did you first notice this problem?

G. Please describe several of your child's strengths:

H. Please describe several of your child's weaknesses:

CURRENT BEHAVIORAL CONCERNS

Please check the behaviors you believe your child **currently** exhibits:

__ High activity
__ Bedwetting
__ Difficulty finishing tasks
__ Unusually aggressive
__ Does not listen
__ A "different" child
__ Difficulty with sleep
__ Gets lost easily
__ Daytime accidents
__ Heedless to danger
__ Pulling out hair
__ Diet restriction
__ Impulsivity
__ Poor attention span
__ Disorganized
__ Excessive swearing
__ Socially Awkward/odd
__ Tics/twitching
__ Worried or anxious
__ Poor awareness of time
__ Clumsy/sloppy
__ Poor memory
__ Binging/Purging
__ Picky eater
__ Interrupts frequently
__ Acts as if driven by motor
__ Accident prone
__ Temper Outbursts
__ Socially withdrawn
__ Does not learn from consequences
__ Problems understanding jokes
__ Does not think logically
__ Low frustration tolerance
__ Chewing/swallowing difficulties
__ Problems changing activities
__ Sees, feels, hear things that are not there
__Talking around issues, can't come to a point
__ Does or says things over and over (perseveration)

FAMILY HISTORY

A. Additional children and other family members living with the family:

Name:	Age:	Medical/social/school problems:

B. For the child's family, is there any history of the following? (Please mark with M= mother, F=father, S=sister, B=brother, GM= grandmother, GF= grandfather, U=uncle, A=aunt, C=cousin) **from the child's perspective**

Mother's side of family

_______ Learning problems
_______ Hyperactivity
_______ Depression
_______ Bipolar Disorder
_______ Genetic Disorder
_______ Metabolic Disease
_______ School problems
_______ Anxiety
_______ Intellectual Disability
_______ Seizure Disorder
_______ Head injury
_______ Other neurologic condition
_______ Attention/Concentration problems
_______ Obsessive-Compulsive Disorder
_______ Alcoholism/Drug Abuse
_______ Developmental Disability
_______ Autism/Pervasive Development Disorder

Father's side of family

_______ Learning problems
_______ Hyperactivity
_______ Depression
_______ Bipolar Disorder
_______ Genetic Disorder
_______ Metabolic Disease
_______ School problems
_______ Anxiety
_______ Intellectual Disability
_______ Seizure Disorder
_______ Head injury
_______ Other neurologic condition
_______ Attention/Concentration problems
_______ Obsessive-Compulsive Disorder
_______ Alcoholism/Drug Abuse
_______ Developmental Disability
_______ Autism/Pervasive Development Disorder

C. Have any of your child's other blood relatives experienced problems similar to those your child is currently experiencing? If so, please describe: ____

PREVIOUS EVALUATIONS
***Please provide a copy of all relevant evaluations/reports.**

Has your child ever received any of the following evaluations: neurological, psychiatric, psychological, neuropsychological, educational, speech & language, or other types of evaluations? If so, provide information below:

Provider Name	Date	Location	Reason for Evaluation	Diagnoses Given

TREATMENT HISTORY

Has your child ever received physical therapy? ☐ Yes ☐ No

Provider Name	Dates	Location	Reason for Treatment	Goals/Outcomes

Has your child ever received occupational therapy? ☐ Yes ☐ No

Provider Name	Dates	Location	Reason for Treatment	Goals/Outcomes

Has your child ever received speech and language therapy? ☐ Yes ☐ No

Provider Name	Dates	Location	Reason for Treatment	Goals/Outcomes

Has your child ever received psychotherapy/counseling? ☐ Yes ☐ No

Provider Name	Dates	Location	Reason for Treatment/Diagnosis	Goals/Outcomes

MENTAL HEALTH HISTORY

1. Has your child been diagnosed or shown symptoms of:

___ Emotional Disorders ___ Behavior Disorders ___ Depression
___ Manic Depression ___ Bipolar Disorder ___ Schizophrenia
___ Phobias ___ Panic attacks ___ Anxiety
___ Eating Disorder

If so, please describe: ____

____

2. Has your child been a victim of emotional, physical, or sexual abuse? If so, please describe:

____

3. Has your child ever received inpatient psychiatric care? ☐Yes ☐No

Program________________________ Dates of attendance________________________

4. Has your child ever attended Residential or Day Treatment Programs (Intensive Outpatient Program)?
☐Yes ☐No

Program________________________ Date of attendance________________________

Program________________________ Date of attendance________________________

5. Have you used in-home services? ☐Yes ☐No

____Family Preservation _____Respite _____In-home Mental Health ____Other

List any other agencies/individual providing regular services not mentioned elsewhere:

Name:____
Address:____
Phone:____
Service:____

Name:____
Address:____
Phone:____
Service:____

DEVELOPMENTAL HISTORY

A. Pregnancy and Birth History

How many weeks did the pregnancy last (normal is 38-42 weeks) ________________

Please list any medications taken during pregnancy:

Medication	Months taken (of 9)	Dose	Reason for taking

1. Was alcohol consumed during the pregnancy? ☐ Yes ☐ No

2. Was smoking or tobacco used during pregnancy? ☐ Yes ☐ No

3. Were there any illnesses during pregnancy? ☐ Yes ☐ No
   If yes, please describe-____

4. Were there any traumas during pregnancy? ☐ Yes ☐ No
   If yes, please describe- ____

5. Was an amniocentesis done during pregnancy? ☐ Yes ☐ No
   If yes, please describe-____

6. Was there any exposure to chemical, toxic substances, or people with infections during pregnancy? ☐ Yes ☐ No
   If yes, please describe-____

7. Were there any difficulties in the child during or immediately after birth? ☐ Yes ☐ No
   If yes, please describe____

8. Birth Weight:_____________ lbs__________oz
   Child's Birth Length______inches
   Apgar score (if known): First:____________ Second:______

B. Developmental Milestones and Concerns

1. Please list age *in months* for each milestone achieved. (Approximate if unsure)

_______ Rolled over
_______ Sat alone
_______ Crawled
_______ Understood no
_______ First word
_______ First sentence
_______ Walked
_______ Peddled a tricycle
_______ Ability to hold crayon to color
_______ Bladder trained (night)
_______ Bowel trained
_______ Bladder trained (day)

2. Did/Does your child receive early intervention services? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

3. Was your child diagnosed with a genetic disorder? ☐ Yes ☐ No If yes, please describe: __________________

4. Were any of the following present to an unusual degree during infancy (0-18 months), Toddler (18 months- 3 years), or Preschool (3-5 years)

I= Infancy, T= Toddler, P=Preschool

_______ High Fevers
_______ Excessive pain/discomfort
_______ Reoccurring ear infections/tubes placed
_______ Poisoning/toxic exposure
_______ Colic/reflux
_______ Poor weight gain
_______ Difficulty sucking/chewing/swallowing
_______ Lethargy
_______ Restless
_______ Disrupted sleep
_______ Difficult to calm/pacify
_______ Irritability/easily pained
_______ Did not like to he held
_______ Aggression
_______ Thumb sucking
_______ Nightmares
_______ Clumsy/uncoordinated
_______ Accident-prone
_______ Highly active
_______ Difficulty making eye contact
_______ Staring or avoiding looking at things
_______ Rocking, spinning, or head banging
_______ Walking on tip toes or flapping hands
_______ Unusual play behaviors
_______ Difficulty interacting/playing with others
_______ Slow to roll, crawl, or talk
_______ Slow to use words or sentences
_______ Loss of abilities/regression
_______ Limited make believe play
_______ Other:_________________________

EDUCATIONAL HISTORY

***If applicable, please include your child's most recent 504/IEP and other relevant psychological/educational testing completed by school.**

A. School/Placement History

Schools Attended	Grades	Academic Concerns	Behavioral Concerns	Social Concerns	504 or IEP?
Preschool					
Kindergarten					
Elementary					
Middle/Junior High					
High School					
Post High School					

B. Educational Supports, Services, and Concerns

1. To the best of your knowledge, at what grade level is your child currently performing?
   Reading __________ Spelling__________ Arithmetic__________ Writing__________

2. Has your child ever been held back or has retention ever been suggested? ☐ Yes ☐ No
   If yes, when? Please explain: ____

3. Has your child ever received Special Education services or received accommodations through a 504 plan?
   ☐ Yes ☐ No If yes, when, and for what services:
   ____
   ____
   ____

4. If applicable, please check your child's classification(s) through Special Education:

___ Autism
___ Cognitive Disability
___ Deafness
___ Developmental Delay
___ Emotional Disability
___ Hearing Impairment
___ Orthopedic Impairment
___ Other Health Impaired
___ Specific Learning Disability
___ Speech or Language Impairment
___ Traumatic Brain Injury
___ Visual Impairment

5. When was the last IEP or 504 Plan, and what were the goals? (Attach if possible) ____________
   ____
   ____

6. Does your child receive any of the following in school:

___ Adapted physical education
___ Occupational therapy
___ Counseling/Social Work
___ Physical therapy
___ Speech therapy
___ Tutoring
___ Behavior Intervention Plan
___ Other: ________________

7. How much time does your child spend each night doing homework?______________________

8. Do you assist your child with homework? If yes, describe: ______________________

9. Does (or has) your child received private tutoring?
   ☐ Yes ☐ No If yes, when? Please explain: ______________________

10. Has/Have your child's classroom teacher(s) reported any of the problems below?

___ Attention/concentration
___ Distractibility
___ Hyperactivity
___ Behavior problems
___ Reading/Spelling problems
___ Poor memory
___ Following Directions
___ Few Friends
___ Does not get along well
___ Withdrawal
___Anxious or sad
___ Math problems
___ Handwriting
___ Aggression
___ Not turning in assignments

11. Does your child participate in extra-curricular activities at school (sports, clubs)? If so, what are they?
    ____

SOCIAL HISTORY

1. Does your child seek out friends?	Never	1	2	3	4	5	Always
2. Do other children seek out your child to socialize?	Never	1	2	3	4	5	Always
3. Does your child relate well to other children?	Never	1	2	3	4	5	Always
4. Does your child understand rules of social interaction?	Never	1	2	3	4	5	Always

5. Are friends: ___Older ___Younger ___Same Age

6. Please explain problems with friendships:

____

____

____

7. Who is your child's best friend?____

8. Is your child different than his/her peers? ☐ Yes ☐ No
Please explain:

____

____

9. Any difficulties with:

___ Being bossy	___ Withdrawn	___ Disinterested in others	___ Perspective taking
___ Initiating play	___ Sharing	___ Making new friends	___ Personal space
___ Group play	___ Compromising	___ Keeping old friends	___ Cooperating
___ Being accepted	___ Individual play	___ Empathy	

10. What are your child's areas of accomplishment?

____

____

11. What does your child enjoy doing most (e.g. leisure activities, hobbies, etc.)?

____

____

12. What does your child dislike doing?

____

____

MEDICAL HISTORY
***Please provide copies of all relevant medical test results/reports.**

1. Primary Care Physician: ______________________________ Phone Number:________________

2. Current Height ______________________ Weight____________________________________

3. Current medical problems for which your child is being treated: ______________________________
____

4. Does your child have allergies to any specific foods, materials, substances, etc.? ☐ Yes ☐ No
   If so, please list/describe: ____

5. Has/Did your child had/have frequent ear infections? ☐ Yes ☐ No

6. Did he/she have pressure equalization tubes placed? ☐ Yes ☐ No
   Age at time of surgery: ____

7. Does your child have any hearing problems? ☐ Yes ☐ No
   Please explain: ____

8. Has your child received an audiological evaluation? ☐ Yes ☐ No
   Date:__________________________ Results: ____

9. Has your child received an ophthalmologic evaluation or vision screening? ☐ Yes ☐ No
   Date:__________________________ Results: ____

10. Does your child use or require any special equipment? ☐ Yes ☐ No
    Please explain: ____

11. Has your child been diagnosed with a neurobehavioral disorder such as:

___ Tourette syndrome
___ ADD/ADHD
___ Dyslexia
___ Processing Deficits
___ Learning Disabilities
___ Autism
___ Asperger's Disorder
___ Hyperlexia
___ Executive Function Disorder
___ Nonverbal Learning Disability
___ Obsessive-Compulsive Disorder
___ Oppositional Defiant Disorder

12. Has your child ever experienced:

___ Meningitis
___ Narcolepsy
___ Head Injury
___ Tumor
___ Tics
___ Stroke
___ Sleep Disorders
___ Coma
___ Headaches
___ Fainting
___ Encephalitis
___ Brain Hemorrhage
___ Loss of consciousness
___ Toxic metal exposure
___ Tremors
___ Vertigo

13. Has your child been diagnosed with:

___ Cerebral Palsy
___ Intellectual Disability
___ Muscular Dystrophy
___ Central Nervous System Structural Defect
___ Multiple Sclerosis
___Genetic Disorder

If so, please describe: ____

14. Describe your child's sleep patterns (e.g., what time your child goes to bed; what time your child wakes up?)
____

15. How many hours does your child typically sleep per night? ___________________________________

16. Does your child sleep in his/her own bed? ☐ Yes ☐ No

17. Does your child exhibit any of the following:
_____ Difficulty falling asleep
_____ Waking up in the night
_____ Frequent nightmares
_____ Bed-wetting

18. Describe your child's eating patterns like (e.g., does your child always eat breakfast?)
____
____

19. Does your child exhibit any of the following:
_____ Picky eater
_____ Refusing to eat
_____ Hoarding food
_____ Hinge eating
_____ Sudden weight gain or loss
_____ Report pain

20. Any other sleep or appetite problems not reported above?
____
____

21. Has your child used:
___ Alcohol ___ Cigarettes ___ Drugs

If so, please describe: ____

22. Has your child ever had a serious head injury?____________(If more than one, describe on the back of this page.)

At that time, did your child lose consciousness?__________ For how long?________________

Was medical treatment given?_____ Where?_________What test results were you given (What were you told?____

Was hospitalization required? _______ For how long? __________ What treatment was given?
____

Following this injury, was there serious headaches, ______memory loss,__________
inattention,_________ confusion,__________ speech problems, learning problems?__________________

MEDICATION HISTORY

Please list **all** past and present medications prescribed and the dosages:

Medication	Prescribed By	Dosage	Date Started/Ended	Response/Side Effects

1. On average, how often does your child receive his/her medication in the correct dosage?
   a. < 50% of the time
   b. 50-80% of the time
   c. 81-100% of the time

2. Is your child responsible for taking any doses of medications? ☐Yes ☐No

3. Are medications supervised? ☐Yes ☐No

4. Is the school responsible for giving any doses of medications? ☐Yes ☐No

Additional Comments:

____
____
____
____
____
____

Thank you for completing this form.

Collaborating to uncover your child's best.