NEURO ASSESSMENT
& DEVELOPMENT
CENTER

PARENT QUESTIONNAIRE

(Please be Descriptive)

FAX: 801-606-7812
Email: info@neurodevelop.com

Please Fax or bring all pertinent reports including: Treatment Summaries, Academic records, Radiology reports, and Previous Psychological or Neuropsychological reports

Today's Date:

Patient Name _____ **Birth date**_____

School & Grade _____
Employer & Occupation _____

Chief Complaint/Presenting Problem (be descriptive):

MEDICAL HISTORY

Mother's Pregnancy

Number of pregnancies prior to this one? _____
Medical problems during pregnancy _____
_____
Fetal movements □ Normal □ Abnormal □ Not sure
Any Drug/Alcohol use during Pregnancy? _____

Birth weight _____ Apgars (if known) _____ Color □ Normal □ Blue
Medical problems during delivery _____
_____

Newborn Problems

□ problems breathing □ 'yellow' (jaundice) □ seizures □ floppy body
□ infections □ brain hemorrhage □ feeding problems □ 'jittery' □ colic
□ hospitalized?

□ Right handed □ Left handed □ Both When noticed? _____

Developmental Milestones (age, in months, if remembered)
Smiled responsively _____ Sat alone _____ Crawled _____ Walked _____
First words _____ Combining words _____ toilet trained _____

Concerns about: □ seeing □ hearing □ attention □ social interaction

Allergies? (drugs or environmental) _____

Medical Illnesses or Conditions
□ Head injury □ Seizures □ ADD/ADHD □ Meningitis □ Sleep Apnea
□ Vision problems □ Hearing problems □ Speech problems □ Dyslexias
□ Coordination problems □ Ear infections □ Poor weight gain
□ Other _____
Describe _____
_____

Current Medications _____
Past Medications _____

Prior Evaluations -- Please provide copies of all prior evaluations to NADC

□ Physician □ Psychologist □ School □Therapist □ Other _____

□ EEG □ Head CT □ Head MRI □ Speech Therapist □ Other Therapy

Do you feel there has been a loss of a previously acquired skill? □ Yes □ No--- Explain
_____
_____

TREATMENT HISTORY (Therapy):

Inpatient/Residential:

1) When _____
Why _____
Name of facility _____

Outpatient Treatment:

1) Name of doctor / therapist _____
When _____
Why _____
_____

2) When _____
Name of doctor / therapist _____
Why _____
_____

RELATIONSHIPS:

Biological parents' marital status: Married Divorced Separated Never Married

If divorced, when? _____ Remarried? Mother: Yes No Father: Yes No

Patient Adopted? Yes No – When?

With whom does the patient live? _____

Dad's Name: _____

His/her occupation: _____

Describe relationship with patient: _____

_____

Mom's Name: _____

His/her occupation: _____

Describe relationship with patient: _____

_____

Siblings	Sex	Age	Live with?	Description of relationship
_____	M F	_____	Yes No	_____
_____	M F	_____	Yes No	_____

Significant Relationships/Friendships

Name	Sex	Age	Description of relationship / how long?
_____	M F	_____	_____
_____	M F	_____	_____

Difficulty making or maintaining relationships? Yes No _____

What problems do you see with Relationships?

_____

_____

Is there a family history of neurologic, learning, psychiatric, or developmental problems? If yes, please describe. Use additional paper if necessary.

_____

_____

_____

_____

Family member with history of:

☐ Reading problems ☐ Writing Problems ☐ Attention Problems ☐ Tourette's
☐ Hearing problems ☐ Speech difficulty ☐ Hyperactivity ☐ Obsessive Compulsive
☐ Bipolar ☐ Learning Disability ☐ Behavior problems ☐ Depression ☐ Suicide
☐ Substance abuse ☐ Other Neurologic or psychiatric illness _____

ACADEMIC HISTORY:

Please describe problems at school:

_____
_____
_____
_____

How does your child feel about school?

_____
_____
_____
_____

	School	Problems	Grades
Elementary			
Middle			
High			

Is there an IEP or 504 Plan currently? _____

Do you have concerns about his / her class or school placement? _____

_____
_____

Are any of the following subjects difficult for child?

	Yes	No	Not Sure	Describe
Art				
Computers				
English				
Foreign Language				
Handwriting				
Math				
Music				
Note Taking				
Reading				
Science				
Social Activities				
Social Studies / History				
Speaking / Discussion				
Sports / PE				
Creative Writing				
Report Writing				

Traits & Behaviors

□ Shyness □ Problems with Transitions □ Refusal to go to School or Daycare
□ Overexcitable at times □ Sensitive to lights or noises □ Tantrums □ Sad
□ Head banging □ Spinning □ Flapping Hands □ Rocking □ Self-destructive
□ Trouble with eye contact □ Making odd noises □ Jerking arms or hands
□ Tilts head or squints while reading □ Poor hand-eye coordination
□ Problems jumping rope, skipping, bicycling □ Confuses Right & Left □ Intense
□ Sense of humor □ Kind □ Creative □ Hardworker □ 'People' person
□ Resilient □ Optimistic □ Pessimistic □ Realistic □ Affectionate

Interests

□ Sports □ Bike riding □ Cars/motorcycles □ Art □ Building Things
□ Music □ Dancing □ Social activities □ Computer games or computer work
□ Writing □ Pets/Animals □ Schoolwork □ Reading □ Math
Other:_____

Mental Energy

□ Trouble staying alert □ Loses focus unless very interested □ Good & bad days
□ Trouble finishing things □ Sleepy or exhausted at school
□ Problems sleeping □ Picky or poor eater

Attention

□ Focuses deeply □ Attention varies depending on subject
□ Distracted by sounds □ Distracted by visual details
□ May focus on unimportant details □ Daydreams □ Craves excitement or novelty
□ Trouble staying seated □ Interrupts conversations □ Blurts out answers
□ Forgets what just heard □ Trouble shifting attention □ Bored easily
□ Creative, has lots of ideas □ Acts impulsively

Work production

□ WNL – able to produce work effectively and efficiently □ A Multi-tasker
□ Trouble planning work □ Doesn't plan ahead □ Cannot plan for large projects
□ Fidgety or overactive □ Disorganized with time □ Careless errors
□ Doesn't notice when bothering others □ Punishment doesn't make a difference

Reading Problems □ Yes □ No

□ Loses place □ Skips words □ Tires easily □ Rubs eyes □ Problems Reading Aloud
□ Omits small words □ Phonics problems □ Comprehension Problems □ Reversals

Writing Problems □ Yes □ No

□ Handwriting problems □ Problems putting ideas into words □ Spelling problems
□ Organization problems

Speech Problems □ Yes □ No

□ Problems putting ideas into speech □ Problems with articulating words
□ Problems talking informally with family or friends

Math Problems □ Yes □ No
□ Problems with basic math facts □ Careless errors □ Reversals □ Concepts

Mood Problems □ Yes □ No
□ Seems moody □ Seems sad □ Has lost interest in favorite activities
□ Negative comments about self □ Believes 'not smart' □ Believes 'not pretty'
□ Often seems down □ Often is grumpy or agitated □ Gets angry, 'flies off the handle'
□ Has unrealistic ideas □ Fluctuates from being sad to very excited
Please describe mood of Patient: _____
_____

Suicidal Ideations/Plans/Behavior? □ Yes □ No
□ Has talked about killing himself/herself
□ Has made plans to hurt or kill himself/herself
□ Has made gestures to harm self? Explain_____
_____

Anxiety Problems □ Yes □ No
□ Worries a lot □ Specific fears, Explain _____
□ Panic Attacks □ Social Phobia □ Is preoccupied with cleanness
□ Obsessions or Compulsions: _____
□ Avoids situations/activities that causes Anxiety
Has the child endured any extremely stressful experiences**?** _____
_____

Bodily Health / Concerns □ Yes □ No
□ Patient is overly or unrealistically concerned with body/health problems
□ Headaches □ Stomach aches □ Hearing problems □ 'What/' or 'huh' alot
□ Distracted by background noise □ Dizziness □ Wets bed/bathroom issues
□ Makes odd sounds □ Has twitches or tics □ Has certain rituals or odd habits
□ Carsickness □ Complains of blurred or double vision
□ Is preoccupied with cleanness □ Complains 'not well' on school days
□ Eating problems: _____

Social Difficulties □ Yes □ No
□ Relates better to adults or younger children □ Lacks close friends
□ Rejected by age group □ Has trouble talking like other kids
□ Is sad about lack of friends □ Says & does things to annoy peers
□ Has trouble making new friends □ Dislikes recess
□ Gets picked on or bullied □ Has trouble with resolving conflicts
□ Has trouble relating to the opposite sex

Behavioral Concerns □ Yes □ No
□ Doesn't accept responsibility □ Disobeys parents
□ Has tantrums □ Uses bad language
□ Argues with siblings □ Argues with Peers □ Argues with other Adults
□ Won't follow rules □ Trouble with authorities □ Legal Problems
□ Stirs up trouble □ Mean to brothers/sisters □ Takes things from others
□ Is mean to animals □ Physical fights □ Problems with Fire Starting

Attention & Sensory Checklist:

Vision:

- ☐ Blurry vision - near or far?
- ☐ Double vision
- ☐ Rubs eyes
- ☐ Tilts head or closes one eye
- ☐ Reading Problems
  - ☐ Skips Lines
  - ☐ Distracted by Visual Details
  - ☐ Distracted by Movement of Others

Hearing:

- ☐ Frequent ear infections
- ☐ Says What? Or Huh? A lot
- ☐ Covers Ears with Moderate Noise
- ☐ Talks Loud
- ☐ Distracted by Sounds
- ☐ Delay Before Answering
- ☐ Problems in Large Groups, Parties
- ☐ Very Sensitive Ears
- ☐ Trouble with Background Noise
- ☐ Doesn't Respond to Name Being Called
- ☐ Repeats Back What's Been Said Before Answering

Sensory Seeking:

- ☐ Likes Crashing, Bumping
- ☐ Always Moving, Hyperactive
- ☐ Chews on Shirt Collars
- ☐ Poor Sense of Personal Space, Leans on Others
- ☐ Wants to Touch Certain Textures
- ☐ Likes to Spin, Flap Hands, or Jump

Balance / Movement:

- ☐ Fears Falling
- ☐ Doesn't like Rough Housing
- ☐ Avoids Some Playground Equipment
- ☐ Prefers to Stand While Writing
- ☐ Insecure with Movement (stairs, escalator)
  - ☐ Unexpected Falls Out of Chairs
  - ☐ Trouble Learning to Ride a Bike

Tactile Sensitivity:

- ☐ Sensitive to Clothing Tags
- ☐ Doesn't like Messy Play or Water Splashes
- ☐ Would prefer wearing little or no clothes at home
- ☐ Avoids Physical Affection, Hugs
- ☐ Likes to Take Off Shoes / Socks

Taste / Smell Sensitivity:

- ☐ Picky eater- revolted by smells, tastes, textures
- ☐ Prefers 'white foods' pasta, mashed potatoes

Sleep / Energy Level:

- ☐ Sleeping Problems
- ☐ Problems Going to Bed
- ☐ Wake in Middle of Night
- ☐ Snores
- ☐ Kicks while Asleep
- ☐ Daytime Sleepiness
- ☐ Nightmares
- ☐ Doesn't Realize When Sleepy or Hungry
- ☐ More fatigued at end of day
- ☐ Fatigues easily
- ☐ Often puts head on desk
- ☐ Floppy or loose muscle tone
- ☐ Weak Grasp
- ☐ Flops When Sitting on Floor

Emotional Regulation:

- ☐ Overload in Loud or Busy Environment
- ☐ Punishment Doesn't Make a Difference
- ☐ Explosive Anger Spell

CURRENT SYMPTOMS

Depression:

Previously diagnosed as depressed?	Yes No
If depressed, has it lasted over 1 year?	Yes No
Is he depressed most of the day, nearly every day?	Yes No
Less interest or pleasure in doing things usually enjoyed?	Yes No
Has weight gone way up or down without dieting? (5% or more)	Yes No
Insomnia or hypersomnia (Sleep) nearly every day?	Yes No
Psychomotor agitation or retardation? (observable)	Yes No
Are they fatigued nearly every day?	Yes No
Do they feel worthless or excessively guilt all the time?	Yes No
Do they have a difficult time thinking or concentrating, or feel indecisive a lot?	Yes No
Do they think about death or suicide a lot of the time?	Yes No

Typical sleeping pattern: _____

Rate level of depression: None Mild Moderate Severe
Did depression occur Before After With Without Drug Abuse?

Anxiety

Have they ever experienced a sudden onset of fear or terror, including pounding heart, sweating, feeling of dizziness, fear of dying, chills, sensation of choking? (panic attack) Yes No

Do they have any specific phobias? (animals, blood, injury, environmental, situation, etc.) Yes No

Are they afraid of social situations and avoid them? (social phobia) Yes No

Do they have habits of repeating behaviors or compulsions, believing that bad things will happen if they don't do those things? (compulsions - OCD) Yes No

Do they have recurrent or persistent thoughts that bother you? (obsessions – OCD) Yes No

Have they had excessive anxiety or worry for over 6 months, more days than not, including difficulty controlling the worry, sleep disturbance, restlessness, or irritability? (GAD) Yes No

Do they re-experience in mind/dreams bad things that have happened to you (PTSD)? Yes No

Types of Trauma Symptoms (circle): Nightmares Flashbacks Reenactment Disassociation

Prominent anxiety or phobic disturbance, unlike the others (Anxiety Disorder NOS) Yes No

Comments: _____

Have they ever experienced a manic episode? Yes No
(lasting at least 1 week: feelings of grandiosity, decreased need for sleep, pressured speech, racing thoughts, distractible, agitated, increase in pleasure-seeking activities, increase in sexual energy)
If yes, describe: _____

Have they ever experienced periods of mania and depression alternating? Yes No

If yes, describe: _____

Have they ever seen or heard things that other people didn't see or hear, when they weren't on drugs? (auditory, visual or other hallucinations) Yes No
If yes, describe: _____

Do they have any beliefs that other people would think are strange? Yes No
(for example getting messages from the TV, receiving messages from an alien, persecutory, grandiose, etc.)
If yes, describe: _____

Have they ever wanted to hurt yourself or anyone else? Yes No

If yes, describe: _____

Have they ever made a suicide plan or attempted suicide? Yes No

If yes, describe: _____

Have they ever cut, burned, carved or deliberately hurt yourself? Yes No

If yes, describe: _____

Do they currently feel suicidal? Yes No

If yes, describe current plan, intent and means: _____

_____

Assess imminence, reality base, dangerousness, history, etc. - Risk: Low Moderate High

Support/Response Plan: _____

Eating:

Do they have an intense fear of gaining weight or getting fat? Yes No

If yes, describe: _____

Do they, or have they ever done, binge eating? Yes No

If yes, describe: _____

Have they ever made theyrself throw up after eating? Yes No

If yes, describe: _____

Other methods they've used to control weight (over-exercise, laxative use, diet pills/ other drugs):

_____

Typical eating pattern: _____

Comments: _____

Conduct:

Are they frequently aggressive towards people or animals (threatening or physical)? Yes No
Do they often destroy property? Yes No
Do they often set fires? Yes No
Do they lie a lot or steal stuff often? Yes No
Do they often break rules like curfew, running away, truant from school? Yes No
Assaultive ideation? Yes No
Comments: _____

Severity: Mild Moderate Severe

ODD:

Do they often lose theyr temper? Yes No
Do they often argue with adults? Yes No
Do they often refuse to comply with rules? Yes No
Do they often deliberately annoy people? Yes No
Do they often blame other people for theyr mistakes? Yes No
Do they often feel touchy or easily annoyed by other people? Yes No
Do they often feel angry or resentful? Yes No
Have these behaviors lasted longer than 6 months,
and caused impairment in social or academic functioning? Yes No

ADD:

Have they been diagnosed with an Attention Deficit Disorder? Yes No

Inattentive Symptoms:

Do they often not pay close attention to what they're doing and make careless mistakes? Yes No
Do they have a tough time keeping theyr attention on tasks they're doing? Yes No
Do they often not seem to listen when people are talking to they? Yes No
Do they often not follow through on instructions and so don't finish assignments? Yes No
Do they have trouble organizing tasks that they're doing? Yes No
Do they avoid things that they know are going to take they a long time? Yes No
Do they often lose things like assignments, books, pencils, etc.? Yes No
Are they easily distracted by other stuff going on around they? Yes No
Are they often forgetful? Yes No

Hyperactive and Impulsive Symptoms:

Do they often fidget or have trouble staying in theyr seat at school? Yes No
Do they often leave theyr seat when they're not supposed to? Yes No
Do they often feel restless? Yes No
Do they have trouble playing games quietly? Yes No
Are they often "on the go," can't sit still long? Yes No
Do they often talk too much? Yes No
Do they often blurt out the answers before the questions have been completed? Yes No
Do they have trouble waiting theyr turn? Yes No
Do they interrupt a lot, butt into other people's conversations or games? Yes No

Primarily: Inattentive Type Hyperactive Type Combined

Comments: _____

Substance Abuse and Addictions History:

Has your child used/abused any drugs or alcohol (including past and present, prescription drugs, over the counter drugs, etc.)? Yes No

Drug	**Frequency/ Quantity Consumed**	**Onset Age**	Last usage	**Period of Abstain. Yrs./Mos.**	**Negative Consequences**	**Sell? Y/N**	**Abuse (A) or Depend. (D)**

Do they use continue despite related problems? Yes No

What related problems? _____

Does their pattern result in any tolerance or withdrawl symptoms? (Circle which ones, if any)
(depression, tremors, hallucinations, fatigue, sweating, chills, sleep problems, agitation, change in appetite, muscle weakness, nausea, anxiety, cravings, vomiting, seizures, confusion)

If student has had these symptoms, are they related to: (circle what applies)
(withdrawl, tolerance, taking more than intended, blackouts/loss of memory, efforts to cut down/control use, excessive time spent on drugs, associated physical problems because of drugs)

Other addictive behaviors?(gambling, stealing, shopping, sex, overeating, internet, etc.) Yes No

Describe: _____

_____