Newton-Wellesley Family Pediatrics
Boston Children's
Primary Care Alliance

617-965-6700 | *fax* 617-965-5239

Parent Questionnaire

Please fill in this form before our appointment. Feel free to leave spaces blank if you do not have the information or do not wish to respond. Thank you for your cooperation. Looking forward to meeting with you.

Date: _____

Patient name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Parent/Guardian #1 mobile phone: _____

Parent/Guardian #2 mobile phone: _____

Patient mobile phone: _____

Patient's school: _____

Grade: _____ Teacher: _____

Does the patient receive any special educational services?

❍ Yes ❍ No

If so, please specify: _____

Parent/Guardian #1 name: _____

Date of birth: _____ Occupation: _____

Any health concerns? _____

Significant health history: _____

Parent/Guardian #2 name: _____

Date of birth: _____ Occupation: _____

Any health concerns? _____

Significant health history: _____

Parents marital status:

Married: ❍ Yes ❍ No Date: _____

Separated: ❍ Yes ❍ No Date: _____

Divorced: ❍ Yes ❍ No Date: _____

Has either parent/guardian remarried? ❍ Yes ❍ No

Name of parent/guardian #1 spouse: _____

Date of birth: _____ Date of marriage: _____

Name of parent/guardian #2 spouse: _____

Date of birth: _____ Date of marriage: _____

Siblings (include half- and step- siblings)

Sibling #1 name: _____ Age: ___ Gender: ___

Sibling #2 name: _____ Age: ___ Gender: ___

Sibling #3 name: _____ Age: ___ Gender: ___

Sibling #4 name: _____ Age: ___ Gender: ___

Do any of your other children receive any special educational services?

❍ Yes ❍ No

Please explain? _____

_____

Are there any significant health problems with brothers or sisters?

❍ Yes ❍ No

If yes, please explain: _____

_____

Family history

Other members of the household not listed above:

_____

Significant deaths in the family:

_____

Significant family illnesses:

_____

Significant hospitalizations for family or patient:

_____

Family history of learning disability, reading problems, retentions or speech problems: ❍ Yes ❍ No

If yes, please explain: _____

Sleep history

Does your child have any difficulty getting to sleep at night? ❍ Yes ❍ No

Does your child wake in the night? ❍ Yes ❍ No

Sleep in a bed other than his/her own? ❍ Yes ❍ No

What is your child's bedtime on school nights? _____

On weekends? _____

What time does your child wake up in the morning? _____

Describe any difficulties with sleep that your child has:

_____

_____

Does your child have electronics in their room? ❍ Yes ❍ No

❑ Mobile phone ❑ Tablet ❑ Computer ❑ Television

Does your child have video games in his room? ❍ Yes ❍ No

Other electronics? _____

Are these electronic devices available to your child in another room in the house? ❍ Yes ❍ No

What room(s)? _____

Developmental history

At what age did your child sit? _____

Crawl? _____

Walk without assistance? _____

Say single words? _____

Say simple sentences? _____

At what age was your child toilet trained? ❑ Day ❑ Night _____

Were there any problems? ❍ Yes ❍ No

If yes, please explain: _____

Educational history

Has your child every experienced difficulty in school? ❍ Yes ❍ No

What has been the nature of his difficulty? ❑ Social ❑ Academic

Please give a brief description of the difficulty:

_____

When was the difficulty first noted? _____

Has your child ever been evaluated by the school? ❍ Yes ❍ No

When? _____

If yes, please provide the reports from the latest evaluation to your mental health provider.

Is your child receiving services under an:
Individual Education Plan (IEP)? ❍ Yes ❍ No

If yes, please provide the IEP to your mental health provider.

Is your child receiving services under Chapter 504? ❍ Yes ❍ No

If yes, please provide the 504 Plan to your mental health provider.

Family illnesses

Please check if there are any of the following in your family

❑ Heart Disease ❑ Alcoholism ❑ Diabetes
❑ Depression ❑ Retardation ❑ Speech difficulties
❑ Hearing difficulties ❑ Seizures (epilepsy) ❑ Learning disabilities
❑ Vision difficulties ❑ Dyslexia ❑ Birth defects
❑ Emotional illness ❑ Cerebral palsy
❑ Hospitalizations for emotional illness

❑ Other medical problem(s): _____

If you have checked an item, please explain:

_____

Does your child have any chronic illnesses or condition(s)? ❍ Yes ❍ No

Please describe and explain:

_____

_____

_____

Has your child taken medications in the past? ❍ Yes ❍ No

What medications? _____

_____

_____

_____

Please list the medications you child is currently taking and for how long:

Med:_____ How long? _____

Med:_____ How long? _____

Med:_____ How long? _____

Med:_____ How long? _____

Med:_____ How long? _____

Med:_____ How long? _____

Med:_____ How long? _____

Med:_____ How long? _____

Pregnancy history

Did you have trouble conceiving? ❍ Yes ❍ No

Was this child adopted? ❍ Yes ❍ No

Are any of your other children adopted? ❍ Yes ❍ No

Did you have any miscarriages? ❍ Yes ❍ No

During pregnancy, did you smoke? ❍ Yes ❍ No

During pregnancy, did you drink alcohol? ❍ Yes ❍ No

What was your weight gain during pregnancy? _____

Please list any concerns or complications during pregnancy:

_____

Did you take any medications during pregnancy? ❍ Yes ❍ No

Labor: ❑ Under 3 hours ❑ Over 12 hours ❑ Breech ❑ C Section

Any complications? ❍ Yes ❍ No

If yes, please explain: _____

Newborn history

Birth weight: _____ Apgar 1 min: _____ 5 min: _____

Jaundice: ❍ Yes ❍ No

Oxygen: ❍ Yes ❍ No

Any complications? ❍ Yes ❍ No

If yes, please explain: _____

Feeding problems: _____

Sucking reflex: _____

Sleeping problems: _____

Activity Level: _____

Daycare history

At what age was your child first put into daycare? _____

What was the setting for the daycare?

❑ Home day care ❑ A day care facility ❑ In your own home

How many days a week was your child in daycare at that time? _____

Were the caregivers? ❑ Paid ❑ Members of the family

At what time was your child dropped off? _____ Picked up? _____

Currently, what are your daycare arrangements? Please explain:

_____

Over the past years, with how many different day care providers or different daycare settings has your child been involved? _____

Please explain: _____

Treatment goals

Please give a brief statement of why you are seeking treatment for your child at this time.

_____

_____

_____

_____

_____

_____

_____

_____

What do you hope will be the outcome of our meetings together?

_____

_____

_____

_____

Thank you for taking the time to fill in this form. Please bring it with you to our meeting.