Prestige Evaluation and Consulting Services, LLC

903 18th Street, Suite 218
Plano, TX 75074
Phone: 214-274-9386; Fax: 214-473-4246

Parent Questionnaire

BACKGROUND/DEMOGRAPHIC INFORMATION

Today's Date:_____ Referred By: _____

Client's Name:_____ DOB: _____ Age/Grade: _____

Gender: _____ Race Identity and Ethnicity: _____

Parent 1: _____ Parent 2: _____

Home Address: _____ Home Address: _____

City: _____ Zip Code: _____ City: _____ Zip Code:_____

Phone Numbers: Phone Numbers:

Home: _____ Home: _____

Cell: _____ Cell: _____

Email: _____ Email: _____

Occupation: _____ Occupation: _____

Do both parents live in the student's home? _____ If not, with whom does the student live? _____

Who has the legal authority to make educational decisions for this child? _____

Primary language spoken in the house: _____ Other languages spoken: _____

PRIMARY INSURANCE INFORMATION: Please completely fill out if you are using insurance benefits for your child. Please note that only PPO, POS and certain EPO plans are accepted.

Primary policyholder name: _____ Relationship to child: _____

Policyholder DOB: _____ Policy holder address (if different): _____

Insurance Company: _____ Plan name: _____
Policy ID # _____ Group # _____

Customer /Mental Health Service Number on back of card: _____

PLEASE SUBMIT A COPY OF BOTH SIDES OF YOUR INSURANCE CARD PRIOR TO THE FIRST APPOINTMENT TO APPOINTMENT@PRESTIGE-ECS.COM

I give permission for Prestige Evaluation and Consulting Services, LLC to bill my child's insurance policy for psychological services rendered.

Parent/guardian signature: _____ Date: _____

I, _____, acknowledge that I am the parent/guardian taking primary financial responsibility for _____unless another party has signed a written document accepting responsibility for payment. The Psychologist assumes both parents have medical decision-making rights unless a court document is submitted stating otherwise.

Parent/guardian signature: _____ Date: _____

For minors of <u>divorced parents</u> or guardians (please initial applicable box):

I_____ acknowledge that I have the legal right to make all mental health decisions for my child. Psychological testing does not need to be approved by anyone but me. *(In this case, please provide relevant pages of divorce decree).* **Parent/guardian Signature:_____ Date: _____**

I _____ have partial or joint custody and share mental health decisions for my child. (*In this case, the other parent/guardian MUST sign the consent for services as well in order for your child to receive psychological testing services.)* **Parent/guardian Signature: _____ Date: _____**

PRESENTING CONCERNS

What are the reasons you are seeking a psychological or educational evaluation for your child? What questions would you like answered as part of the evaluation?

_____

_____

_____

_____

_____

_____

MEDICAL AND DEVELOPMENTAL HISTORY

Birth weight? _____ Weeks' gestation? _____ Weight gain during pregnancy? _____

Please describe any pregnancy complications? _____

Please name any prescription meds taken during pregnancy? _____

Please describe any difficulties/procedures during labor/delivery (e.g., C-section, forceps used, baby yellow, incubator, baby needed oxygen, etc.): _____
_____
_____

Is your child adopted? _____ If yes, how old was he/she when adopted? _____

Does your child know that he/she is adopted? _____ If yes, did your child's response to this information require counseling or therapy? _____

Is your child a foster child? _____ If yes, how long has he/she been in your home? _____

Behaviors Observed	Never	0-6 Months	7-12 Months	13-18 Months	19-24 Months	2-4 Years	5-7 Years	8-12 Years	13+ Years
Crawl									
Babble									
Say first meaningful word (not mama or dada)									
Talked clearly enough so that strangers understood									
Walk by him/her self									
Use 2-3 word phrases									
Speak in complete sentences									
Complete toilet training									
Began bicycle riding without training wheels									
Had difficulty separating from parents									

Please provide information regarding any injury, surgery, or hospitalization	Age	Describe Treatment and / or Complications

Please check any of the following conditions that your child has or have had:

_____ Concussion
_____ Convulsions/ Seizures
_____ Sudden weight gain
_____ Meningitis
_____ Heart Disease
_____ Fainting
_____ Unexplained weight loss
_____ Lead poisoning
_____ Leukemia/Cancer
_____ Ulcers
_____ Frequent upset stomach
_____ Asthma
_____ Cerebral Palsy
_____ Dental problems
_____ Diabetes
_____ Several ear infections
_____ Frequent or severe headaches
_____ Allergies/ sinus problems
_____ Tonsillitis
_____ High fevers
_____ Hypoglycemia
_____ Skin problems
_____ Frequent colds
_____ Other: _____

Has your child experienced a head injury resulting in a loss of consciousness? _____

If yes, how long was your child unconscious? _____ Was rehabilitation therapy required?_____

If yes, how long was rehabilitation and describe treatment? _____

Please rate your child in each of the following areas:

	Good	Fair	Poor
Health			
Hearing- **Date of last screening _____**			
Vision- **Date of last screening**			
Gross Motor Coordination			
Fine Motor Coordination			

Does your child wear glasses? _____ If yes, for how long? _____

Has your child ever had ear tubes? _____ If yes, how many sets and at what ages?_____

Does your child take any medications other than vitamins? _____ If yes, please list the following:

Medication	Frequency	Dosage	Start Date	Date of Discontinuation

Does your child experience any side-effects of the medication? ____ If yes, please specify:

_____

_____

Please list ***all medical and psychological diagnoses*** which have been provided by health care providers.

_____

_____

Do you suspect that your child has used drugs, alcohol, inhalants, and/or other substances currently or in the past?_____ If yes, please explain

_____

_____

What time does your child go to bed at night and awaken in the mornings? Describe any sleep problems your child has. Have any changes in sleeping patterns or habits been observed?

_____

_____

Does your child eat 3 meals per day? ____ Please describe any eating problems, food aversions or concerns you may have.

_____

_____

_____

FAMILY HISTORY

Please list all household members and siblings:

Age	Relation	Gender	If sibling, does he or she reside at home Yes/No	Any relevant details (how is their relationship, where they are, other important details etc.)

_____
_____
_____
_____
_____
_____
_____

For ***biological parents and siblings***, put a √ in the box if that person has had these experiences.		MOTHER	FATHER	BROTHER	SISTER	OTHER
	Attention problems					
	Learning problems					
	Kept back in school					
	Articulation problems or stuttering					
	Problems understanding instructions					
	Problems using words					
	Mental Retardation					
	Genetic Disorders					
	Autism Spectrum Disorder					
	Behavior problems					
	Depression or Mood Disorder					
	Bipolar/Manic-depression					
	Anxiety Disorder					
	Tics/Tourettes					
	Obsessive/Compulsive Disorder					
	Other Mental Illness, please specify					
	Long Term Illness					
	Suicide					
	Drinking/Drug abuse					

Has there been any serious illness/injury within the family? ___ Yes ___ No; If yes, who and when?

_____

Has there been a recent death in the family? ___ Yes ___ No; If yes, when? _____

Has the family moved or the child changed residences recently? ___ Yes ___ No; If yes, when? _____

Any other major family events? ___ Yes ___ No; If yes, when and what? _____

EDUCATIONAL HISTORY

Please list all schools your child has attended, including preschool:

Name of School	Grades attended	Location

Did your child repeat a grade? _____ If so, which grade and why? _____
What are your child's academic strengths? _____
What are your child's academic weaknesses? _____
Is your child currently at risk for not passing a subject area or his/her grade for the year? Please explain.
_____
_____

When did you first become concerned about your child's academic abilities and/or performance?
_____

Check any previous help or services your child has received:

- ☐ ECI
- ☐ PPCD
- ☐ Speech therapy
- ☐ Oral language therapy
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Summer School
- ☐ Academic Tutoring
- ☐ Resource Class
- ☐ Response to Intervention (RtI)
- ☐ Special Education
- ☐ Dyslexia
- ☐ Section 504 Accommodations
- ☐ Classroom Accommodations
- ☐ Testing Accommodations
- ☐ Academic Language Therapy
- ☐ Helping Teacher/Content Mastery
- ☐ Behavioral/Emotional Disorders Class

Other: _____

List all previous educational and psychological evaluations your child has had (and attach copies):

Please indicate which, if any, of the following issues have affected your child's schooling:

	In which grades?
Failure to follow/retain directions	
Failure to complete/turn in work	
Disorganization	
Inattentiveness	
Impulsivity	
Disruptive	
Oppositional Behavior	
Detentions	
In School Suspensions	
Out of School Suspension	
Expulsions	

Parent Observations

Rate how often your child has these problems **0 = Rarely 1 = Sometimes 2 = Often**	**0**	**1**	**2**
Blurts out answers in class			
Interrupts others			
Talks excessively when it is inappropriate			
Speaks for long stretches with only brief pauses.			
Speaks much louder than socially acceptable			
Fails to modulate voice volume appropriately			
Appears rude or "in your face."			
Trouble identifying misunderstandings of instructions			
Difficulty monitoring comprehension of orally presented information			
Trouble elaborating verbally on his or her ideas			
Problems making clear explanations on request			
Difficulty answering questions concisely using specific vocabulary			
Trouble understanding social cues			
Struggles to consistently sound out words when reading.			
Makes mispronunciations when reading aloud.			
Can memorize for spelling tests, but cannot remember words one week later.			
Spelling is very difficult to read or “make out” (“thucvn” for vacation).			
Often spells words the way they sound (“vaykayshun” for vacation).			
Slow contextual reading speed			
Inconsistent reading accuracy			
When reading, calls a word that means the same as the word in the passage.			
Adds or omits words when reading.			
Repeats words or phrases when reading.			
Fails to recall details from what he has read.			
Struggles to recognize cause/effect relationships when reading.			
Unable to draw conclusions, predict outcomes or make inferences when reading.			
Slow and effortful and/or fast and careless approach to written work			
Untidy, uneven, illegible handwriting			

Rate how often your child has these problems **0 = Rarely 1 = Sometimes 2 = Often**	**0**	**1**	**2**
Poor planning and disorganization of written work			
Poor written sentence construction			
Poor story composition (missing story elements, missing reasons or conclusion)			
Handwriting is slow and laborious			
Uses incorrect grammar (verb tense, noun tense) in written work.			
Written sentences do not make sense.			
Unable to consistently use transition words when preparing written work.			
Inconsistent or rare use of modifiers when preparing written work.			
Struggles to organize good ideas into good written narratives.			
Trouble with sequencing for math			
Trouble learning meanings of words used for math.			
Problems learning math facts.			
Trouble understanding the language of math word problems.			
Trouble solving math problems involving time.			
Makes math procedural errors (carrying and borrowing, division, fractions)			
More overt (out-loud) self-talk to guide actions (rather than using inner speech)			
Slow computation speed			
Difficulty retrieving number facts quickly and accurately			
Trouble ignoring irrelevant information in word problems			
Difficulty solving math problems with multiple procedures or steps			

Study Habits

Homework: Done easily? _____ With difficulty? _____
Needs help with (describe): _____

Studies: When? _____ Where?_____ How long? _____

Does your child put off studying until last minute? Please explain

_____
_____
_____

Does your child like school? Please explain

_____
_____

SOCIAL/EMOTIONAL/BEHAVIORAL HISTORY

What are your child's strengths (emotional, behavior, and/or social)?

_____
_____
_____
_____

Check any of these that describe your child:

_____ Generally happy
_____ Gets over disappointments quickly
_____ Is Responsible
_____ Is Even-Tempered
_____ Polite/Good Manners
_____ Eager to Please
_____ Overly Active
_____ Has tantrums
_____ Easily over-stimulated
_____ Difficulty adapting to routine
_____ Impulsive
_____ Needs directions repeated
_____ Is immature
_____ Exaggerates or tells lies
_____ Takes things
_____ Bullies Others
_____ Is argumentative
_____ Fears many things
_____ Physically/verbally aggressive
_____ Difficulty adapting to change
_____ Lacks self-control
_____ Runs away from home
_____ Cries Excessively
_____ Demands attention
_____ Anxious/Nervous/ Excessive worries
_____ Has memory difficulties
_____ Always tired/Sleep Difficulties
_____ Complains of sickness and pain often
_____ Daydreams
_____ Difficulty answering questions sensibly

What are some of the struggles your child is facing?

_____ Social problems with peers
_____ Behavioral problems at home
_____ Behavioral problems at school behaviors
_____ Low self-esteem
_____ Family problems
_____ Anger management
_____ Trauma history
_____ Psychosis (hallucinations/delusions)
_____ Poor coping skills
_____ Panic attacks
_____ Relationship probs: (w/whom?_____)
_____ Grief /Loss
_____ Gender identity/Sexuality
_____ Apathy
____ Attachment issues
____ Suicidal thoughts or behaviors
____ Self-harming
____ Nightmares
____ Adjustment issues
____ Disordered Eating Behavior
____ Other:_____

Does your child change mood often and without provocation? Please explain.

_____

_____

Your child is (**easy or difficult**) to manage. Do both parents agree?

_____

_____

Please answer the following questions regarding your child's behavior.

BEHAVIORS	YES OR NO	ADDITIONAL INFORMATION
Is your child more interested in objects than people?		
Does your child demonstrate self-stimulating behaviors? _ Rocking _ Arm Flapping _ Hand movement _ Other:		
Does your child demonstrate head-banging or other self-injurious behaviors?		
Does your child exhibit ritualistic or compulsive behaviors?		
Does your child have unusual or special fears, habits, or mannerisms?		
Other:		

Has your child ever seen a mental health professional before (psychologist, counselor, etc.)? ___Yes ___ No;
If yes, who, when, for how long, and for what reason?

_____

_____

_____

What does your child like to do for fun, both alone and with family?

_____

_____

Does your child participate in any organized team sports or organizations as part of or outside of school (e.g. Scouts, YMCA, Youth groups, Cheerleading, Student Council, Select Team Sports, etc.)? Please specify each one and whether or not the experience has been positive for your child? Also, are there any concerns regarding your child's participation in any of these activities?

_____

_____

_____

Please describe any unusual behavior you have observed at these activities:

_____
_____
_____

Peer Relations

Are you ever concerned that your child doesn't play well with other children? YES or NO Please describe:

_____
_____
_____

Does your child have difficulty with any of the following? Please:

___ Sharing with others	___ Making Friends	___ Keeping Friends	___ Taking turns in conversation
___ Playing with toys in their intended manner	___ Involving others in play (play is parallel)	___ Understanding jokes or when he/she is being joked with	___ Initiating conversations with others
___ Taking interest in the interest of others	___ Speaks at length about very specific topics and finds ways of introducing the topic into conversations with others	___ Trouble reading social cues (i.e.- unaware of when conversations are over, peers are no longer interested in interacting or want to be bothered)	___ Making eye contact when speaking

Discipline

For what primary reason or behavior is your child disciplined at home?

_____
_____
_____

To your knowledge, for what primary reason, or behavior, is your child disciplined at school?

_____
_____
_____

What methods of discipline are utilized at home and is discipline effective?

_____
_____
_____

What is your child's typical response to discipline?

_____
_____

What other information would you like to share about your child's social, emotional, and behavioral history?