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PARENT QUESTIONAIRE (0-5 YEARS)©

Patient's Name:	Today's Date:
Address:	Date of Birth: Gender:
City: State: Zip:	Parents' Names:
Home Phone:	Referred by:
Work Phone:	Physician's Name:
Parents' Cell Phone(s):	School: Current Grade:
Parents' Second Cell Phone:	Parents' E-mail Address:

Reason for today's visit:
Prior evaluations/treatments (list names and places of service):
Name of Person Responsible for Payment:
Responsible Person's Relationship to the Patient:
Responsible Person's Home Address:
City: State: Zip:
Responsible Person's Place of Employment:

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize Robert D. Wells, Ph.D. and Associates to provide treatment to _____ and I agree to pay all fees and charges for such treatment. I further agree that I will pay all fees and charges promptly and in full upon presentation of the billing statement unless credit arrangements are otherwise agreed upon in writing. The charges shown by such billing statements are agreed upon to be correct and reasonable unless protested by me in writing within 30 days of the billing date indicated thereon. In the event that legal action is necessary to collect any unpaid balances due for services rendered, I agree to pay reasonable attorney's fees or other such costs as the court determines proper. All account balances that are 60 days overdue are charged an interest fee of 1.5% per month (18% per year). It is our policy to charge for sessions that are missed or not cancelled 48 hours in advance. I agree to the above stated conditions.

Signature Date

Please list any concerns you want help for regarding your child:

Has this child had previous evaluations within or outside of the school? If so, please list below, what evaluations were conducted. If you can recall the date and the person who conducted the evaluation, please list this as well.
It would be helpful if you can attach any available report(s):

Has this child received any special treatments (diets, medications, counseling, psychiatric help, tutoring, speech therapy, etc)? If so, please list below and specify the type of treatment and the approximate dates it was initiated and ended:

The following checklist helps us determine whether medical factors might be important. Please answer the following questions as completely as you can. If you cannot remember something, please check the "cannot say" column for that item.

Possible Pregancy Problems	True	Not True	Cannot Say
Had previous miscarriages			
Had an infection while pregnant			
Bleeding during pregnancy			
Had toxemia			
Had to take medications (please list below)			
Vomited often			
Got hurt or injured			
Stressful or difficult time emotionally			
Took narcotic drugs			
Smoked cigarettes			
Labor lasted longer than 12 hours			
Had a cesarean section			
Had a difficult delivery			

Length of pregnancy _____months

Please list any medications taken during pregnancy:

Please list any pregnancy problems or illnesses:

Newborn Infant Problems	True	Not True	Cannot Say
Injured during birth			
Had trouble breathing			
Turned blue			
Born with cord around neck			
Was a twin or triplet			
Had an infection			
Was given medications			
Had seizures			
Had diarrhea			
Needed oxygen			
Was in hospital for more than 2 days			
Was transferred to a neonatal intensive care unit			
Gagged or vomited often			
Born with heart defect			
Born with other defect (s)			
Had trouble sucking			
Had skin problems			
Was jittery			
Got yellow (jaundice)			

Baby's birth weight_____lbs.

Please list any other newborn health problems:

Health Conditions during Infancy, Childhood, & Adolesence	Ever True	Currently True	Not True	Cannot Say
Ear infections				
Rashes or skin problems				
Meningitis				
Seizures				
High Fevers (over 103 degrees F)				
Pneumonia				
Asthma				
Slow weight gain				
Trouble with ears or hearing				
Trouble with eyes or visions				
Bowel problems				
Hospitalizations				
Surgery				
Serious injury				
Concussion, head injury or loss of consciousness				
Allergies				

Health Conditions during Infancy, Childhood, & Adolesence	Ever True	Currently True	Not True	Cannot Say
Anemia				
Lead poisoning				
Heart problems				
Kidney or urinary problems				

Other important illnesses:

Medications used over a long period:

Functional Conditions	Ever True	Currently True	Not True	Cannot Say
Feeding difficulties or eating problems				
Poor appetite				
Unwilling to try new foods				
Unpredictable appetite				
Overeating				
Colic				
Constipation				
Abdominal Pains				
Trouble falling asleep				
Trouble staying asleep				
Unpredictable length of sleep				
Nightmares				
Night terrors, sleep walking, or sleep talking				
Requires parent in room to fall asleep				
Wakes up in middle of night and comes to parents' bedroom				
Temper tantrums				
Self-destructive behavior				
Difficulty in being comforted or consoled				
Stiffness or rigidity				
Looseness or floppiness				
Crying often easily				
Shyness with strangers				
Irritability				
Extreme reaction to noise, strong tastes, smells or clothing				
Difficulty in keeping to a schedule				
Unwillingness to go along with change in daily routine				
Trouble getting satisfied				
Desire to be held too often				

Functional Conditions	Ever True	Currently True	Not True	Cannot Say
Failure to be affectionate toward parents				
Tendency to make odd sounds, grunts, or snorts				
Tendency to twitch or jerk arm or head				

Please use the checklist listed below to describe this child's developmental milestones, if you cannot recall, please leave blank.

Early Development	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	4-5 years	5-6 years
Sat up without help									
Crawled									
Walked alone									
Walked up stairs									
Rode a tricycle									
Caught a big ball									
Spoke first words (Mama, Dada, etc.)									
Put words together (Daddy bye-bye, Mamma, home, etc.)									
Spoke 2-3 word sentences									
Spoke clearly so strangers understood									
Used fingers to feed self									
Used a spoon									
Fully bowel trained									
Fully bladder trained									
Able to dress self									
Able to tie shoelaces									
Able to separate easily from parent									

Did your child attend a preschool or nursery school ? no

If so, were any problems with behavior noted? no

Were any problems in learning noted? no

Was your child ever retained in a grade? no

If so, which grade (s) was repeated?_____

Family History	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Other Relative (Specify)
Attention problems or hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Speech problems					
Behavior problems in childhood					
In trouble as teen					
Kept back in school					
An honor student					
Depression					
Anxiety					
Bi-polar manic depressive illness					
Drug or alcohol problems					

Father's current age:_____ School level completed:_____
Present occupation:_____ General health:_____
Mother's current age:_____ School level completed:_____
Present occupation:_____ General Health:_____
Brother (s) names and current ages:_____
Sister(s) names and current ages:_____
What is the principal language spoken at home?_____
What other languages are spoken at home?_____

Please check any that apply:

- ☐ Was adopted
- ☐ Is a foster child
- ☐ Parents are separated
- ☐ Parents are divorced
- ☐ One or both parent(s) are deceased

Child lives mainly with:

- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Grandparent(s)
- ☐ Other:_____

Early Developmental Skills	Did Well	Had Mild Problems	Had Serious Problems	Cannot Say
Behavior in nursery school or preschool				
Balancing				
Throwing a ball				
Carrying things				
Running				
Hopping, jumping				

Early Developmental Skills	Did Well	Had Mild Problems	Had Serious Problems	Cannot Say
Using a pencil for drawing				
Making things with blocks				
Dressing self, except for shoes				
Cutting with scissors				
Pouring water into a cup				
Using a knife and fork while eating				
Understanding spoken instructions				
Reciting a nursery rhyme, song, etc.				
Telling a story				
Finding the right words for things				
Pronouncing words				
Remembering spoken instructions				
Remembering names of objects				
Remembering familiar places				
Learning names of letters				
Learning numbers				
Understanding time relationships (before, after, etc.)				
Remembering things in the correct order				
Following instructions				
Loooking through books alone				
Using a pencil to try to write				
Playing imaginary games and make believe				
Imitating adults at work				
Trying to play sports				
Showing an interest in how things work				

Please list any other strengths or skills not listed above:

Specific Interests	Has Little or No Interest	Has Moderate Interest	Has Strong Interest
Playing a sport			
Dancing			
Building models			
Drawing. painting, and other craft work			
Collecting things			
Listening to music			
Playing a musical instrument			

Specific Interests	Has Little or No Interest	Has Moderate Interest	Has Strong Interest
Religion			
Fishing or hunting			
Boy or Girl Scout (or other clubs)			
Writing stories and poems			
Bicycle riding/skateboarding			
Cars/motocycles			
Reading for pleasure			
Pets/animals			
Playing computer games			
Learning about science			

Please list other interests:

Current Adjustment and Functioning	Not True (As Far As You Know)	Somewhat or Sometimes True	Very True or Often True
1. Acts too young for his/her age			
2. Allergy			
3. Argues a lot			
4. Asthma			
5. Behaves like opposite sex			
6. Bowel movements outside toilet			
7. Bragging, boasting			
8. Can't concentrate, can't pay attention for long			
9. Can't get his/her mind off certain thoughts - Please describe:			
10.Can't sit still, restless or hyperactive			
11. Clings to adults or too dependent			
12. Complains of loneliness			
13. Confused or seems to be in a fog			
14. Cries a lot			
15. Cruel to animals			
16. Cruelty, bullying or meanness to others			
17. Daydreams or gets lost in his/her thoughts			
18. Deliberately harms self or attempts suicide			
19. Demands a lot of attention			
20. Destroys his/her own things			

Current Adjustment and Functioning	Not True (As Far As You Know)	Somewhat or Sometimes True	Very True or Often True
21. Destroys things belonging to his/her family or others			
22. Disobedient at home			
23. Disobedient at school			
24. Doesn't eat well			
25. Doesn't get along with other kids			
26. Doesn't seem to feel guilty after misbehaving			
27. Easily jealous			
28. Eats or drinks things that are not food - (don't include sweets) - Please describe:			
29. Fears certain animals, situations or places other school - Please describe:			
30. Fears going to school			
31. Fears he/she might think or do something bad			
32. Feels he/she has to be perfect			
33. Feels or complains that no one loves him/her			
34. Feels others are out to get him/her			
35. Feels worthless or inferior			
36. Gets hurt a lot, accident prone			
37. Gets in many fights			
38. Gets teased a lot			
39. Hangs around with others who get in trouble			
40. Hears sounds or voices that aren't there. - Please describe:			
41. Impulsive or acts without thinking			
42. Would rather be alone than with others			
43. Lying or cheating			
44. Biting fingernails			
45. Nervous, high strung or tense			
46. Nervous movements or twitching - Please describe			
47. Nightmares			
48. Not liked by other kids			

Current Adjustment and Functioning	Not True (As Far As You Know)	Somewhat or Sometimes True	Very True or Often True
49. Constipated, does not move bowels			
50. Too fearful or anxious			
51. Feels too guilty			
52. Overeating			
53. Overtired			
54. Overweight			
55. Physical problems without known medical causes			
56. Aches or pains (not stomach or headaches)			
57. Headaches			
58. Nausea, feels sick			
59. Problems with eyes (not if corrected by glasses)			
60. Rashes or other skin problems			
61. Stomachaches			
62. Vomiting, throwing up			
63. Other physical problems - Please describe:			
64. Physically attacks people			
65. Picks nose, skin or other parts of body. - Please describe:			
66. Plays with own sex parts in public			
67. Plays with own sex parts too much			
68. Poor school work			
69. Poorly coordinated or clumsy			
70. Prefers being with older children			
71. Prefers being with younger children			
72. Refuses to talk			
73. Repeats certain acts over and over - Please describe:			
74. Runs away from home			
75. Screams a lot			
76. Secretive, keeps things to self			
77. Sees things that aren't there - Please describe			

Current Adjustment and Functioning	Not True (As Far As You Know)	Somewhat or Sometimes True	Very True or Often True
78. Runs away from home			
79. Screams a lot			
80. Self conscious or easily embarrassed			
81. Sets fires			
82. Sexual problems - Please describe:			
83. Showing off or clowning			
84. Shy or timid			
85. Sleeps less than most kids			
86. Sleeps more than most kids during day and/or night			
87. Smears or plays with bowel movements			
88. Speech problems - Please describe:			
89. Stares blankly			
90. Steals at home			
91. Steals outside the home			
92. Stores up too many things he/she doesn't need - Please describe:			
93. Strange behavior - Please describe:			
94. Strange ideas: Please describe:			
95. Stubborn, sullen or irritable			
96. Sudden changes in mood or feelings			
97. Sulks a lot			
98. Suspicious			
99. Swearing or obscene language			
100. Talks about killing self			

Current Adjustment and Functioning	Not True (As Far As You Know)	Somewhat or Sometimes True	Very True or Often True
101. Talks or walks in sleep - Please describe:			
102. Talks too much			
103. Teases a lot			
104. Temper tantrums or hot temper			
105. Thinks about sex too much			
106. Threatens people			
107. Thumb-sucking			
108. Too concerned about neatness or cleanliness			
109: Trouble sleeping - Please describe:			
110. Truancy, skips school			
111. Underactive, slow moving or lacks energy			
112. Unhappy, sad or depressed			
123. Unusually loud			
124. Uses drugs for nonmedical purposes (don't include alcohol or tobacco) - Please describe:			
125. Vandalism			
126. Wets self during the day			
127. Wets the bed			
128. Whining			
129. Wishes to be of opposite sex			
130. Withdrawn, doesn't get involved with others			
131. Worries			

Strengths	Often True	Occasionally True	Seldom True	Cannot Say
Has an easy disposition, is easy to live with				
Usually seems happy				
Is likeable				
Easily becomes involved in many activities				
Appeals to adults				
Is affectionate				
Is kind or sympathetic if someone else is sad or hurt				
Is friendly and outgoing				
Plays well with other children				
Shares toys with other children				
Accepts rules easily				
Plays gently with smaller children and animals				
Enjoys playing with other children				
Takes turns well				
Tolerates minor bumps and scratches without much complaint				
Tolerates criticism well				
Handles frustration well				
Is forgiving				
Stands up for himself/herself when necessary				
Recovers easily after disappointments				

Please use the space below to let Dr. Wells know anything else you feel would be helpful for him to be aware of.
Thank you for your time!