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Parental Assessment of Child

Child's Name _____

Child's Date of Birth _____

Gender _____

Age of Child _____

Grade _____

School Child Attends _____

Name of Child's Teacher _____

Name of Child's Legal Mother (s) _____

Phone Number of Mother (s) _____

Name of Child's Legal Father (s) _____

Phone Number of Father (s) _____

Who referred you to this practice _____

Child's Primary Home Address

Other Address' The Child May Reside

Who Has Primary <u>LEGAL</u> custody of the child _____

Who Has Primary <u>PHYSICAL</u> custody of the child _____

If there shared LEGAL and/or Physical Custody of the child, please explain the situation below. Also please provide dates that custody issue first began and any Legal professionals involved in this case.

_____

_____

Please list any siblings and the age of each sibling

_____

_____

Do all siblings currently reside in the home with the child? YES NO

If No, Please explain _____

_____

Does your child get along with sibling (s) YES NO

If no, please explain _____

_____

Please list all people who currently reside in the child's home (s)

_____

_____

Are there other significant people in the child's life (close friends, aunts, uncles, cousins, grandparents, etc) that spend regular time with the child

_____

Primary Occupation of Mom (s) _____

Primary Occupation of Dad (s) _____

Name of Child's Primary Physician _____

Date of Last Physical Exam _____

Any concerns mentioned by Physician at last physical exam YES NO

If yes, please explain _____

Does the child have any current medical conditions **YES** **NO**

If yes, please explain _____

Has the child ever had any surgeries **YES** **NO**

If yes, please explain and list dates these surgeries took place

_____

Is the child currently taking any medications **YES** **NO**

If yes, Please List all Medications and Doses _____

Has your child ever received services for speech, hearing, vision, sensory issues, or not meeting appropriate developmental milestones **YES** **NO**

Has your child ever received psychological services **YES** **NO**
If yes, please explain below (listing ages, psychological issues/testing, and provider (s)

Family history of mental health concerns **YES** **NO**

If yes, please explain

Maternal side of family

_____

_____

Paternal Side of family

_____

_____

Has your child ever experienced physical abuse, sexual abuse, psychological abuse, verbal abuse, or neglect YES NO

If yes, please explain _____

_____

What is the primary reason you are seeking services for your child

_____

How does your child feel about coming here _____

How do you feel about bringing your child here _____

What have you observed to be your child's favorite activity of play

_____

_____

What subjects in school does your child MOST enjoy and LEAST enjoy

_____

_____

Does your child tend to make friends easily _____

Does your child participate in extracurricular activities YES NO

If yes, please list the activities and the amount of time involved weekly for this activity

_____

_____

Does the child attend after-school care or day-care **YES** **NO**

If yes, please list what facility and how long the child has attended

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Please briefly list the weekday morning routine for your child

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Please list the evening weekday routine for your child

Time child wakes up during school weekdays _____

Time child goes to sleep during school weekdays _____

Time child wakes up on weekends _____

Time child goes to sleep on weekends_____

Does your child take a nap _____ For how long _____

Do you feel your child is getting enough sleep _____

Do you give your child any natural supplements to sleep _____

Is it easy of difficult for your child to fall asleep _____

It is easy or difficult for your child to wake up in the morning _____

Does your child have their own room **YES** **NO**
Does your child sleep in their own bed **YES** **NO**

Does your child have any nightmares **YES** **NO**

Does your child ever sleep walk **YES** **NO**

Do you eat dinner together as a family **YES** **NO**

What type of food is your child willing to eat _____

Do you feel your child is getting proper nutrition **YES** **NO**

If no, please explain _____

Does your child take any vitamin supplements **YES** **NO**

Does your child have any food allergies or behavioral issues after eating certain foods **YES** **NO**
If yes, please explain

Does the child own a cell phone **YES** **NO**

Does your child have a tablet **YES** **NO**

Does your child own a video game system **YES** **NO**

Does your child have a television in their bedroom **YES** **NO**

Does your child have their own computer **YES** **NO**

Is your child on any social media sites **YES** **NO**

If yes, which ones _____

Are there parental controls on the child's devices **YES** **NO**

What are your child's favorite shows to watch _____

What video games does your child play _____

What is the total amount of screen time your child your child has per day

Less than 1 hour **1 to 2 hours** **2 to 3 hours** **more than 3 hours**

What are some of things that you do as a family _____

Have there been any major changes in your child's life recently (moving, divorce, new sibling, death in family, loss of job, etc) YES NO

If yes, please explain _____

Does your child have any academic difficulties at school YES NO

If yes, please explain _____

Does your child have any social difficulties at school YES NO

If yes, please explain _____

Does your child have a current 504 plan or other plan at place in school

If yes, please explain _____

Do you have any concerns about your child's school YES NO

If yes, please explain _____

Has your child taken a leave of absence from school YES NO

If yes, please explain _____

Has your child ever refused to go to school YES NO

If yes, how did you handle the situation _____

Has your child ever experience bullying at school YES NO

Has your child ever be accused of being a bully at school YES NO
How would you describe your child's personality _____

How do you discipline your child _____

Do you find your disciplinary techniques effective **YES** **NO**

Are your disciplinary techniques consistent **YES** **NO**

What are the top issues you find yourself having to discipline your child for

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Do you feel emotionally connected to your child **YES** **NO**

If no, please explain _____

Do you feel confident in your parenting skills **YES** **NO**

If no, please explain _____

Please place an X next to each issue that applies to your child

Bed wetting
Nightmares
Not potty-trained
Tantrums
Excessive activity level
Easily distracted
Excessive sensitivity
Fearful
Shy
Depressed
Anxious
Nail Biting
Picking at Skin
Extreme Fatigue
Headaches
Dizziness
Excessive somatic concerns
Poor eating
Prefers to be alone
Inability to be comforted
Aggressive
Biting
Hitting
Defiant
Fighting with siblings
Fighting with adults
Fighting with peers
Hates School
Self Harm
Abuse towards animals
Stubborn
Clumsy
Sucking thumb
Low self-confidence
Inability to leave parent
Moody
Detached
Rocking of body
Repetitive behaviors
Overeating
Restless
Forgetful
Orderly
Messy

Please use the space below to share positive qualities about your child

_____

_____

_____

Is there anything else that you would like us to know that has not been asked?

_____

_____

_____

Has Your Child Ever Been Exposed to or Bitten by a Tick? Yes No

If yes, please explain:

_____

_____

***Lyme Disease can often cause many behavioral and psychological issues in children. It is important to assess for this during a psychological evaluation.**