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CNS Pediatric Questionnaire (to be filled out by Parent/Guardian)

PLEASE READ: Please fill out and mail/fax to CNS prior to the evaluation.
*****Please attach any prior reports or information from various doctors, therapists or school officials that you think will be helpful.***

Name of person being evaluated: _____ Date of Birth: _____
Gender/Preferred Pronoun: _____
Date of Evaluation: _____

Name of person completing questionnaire: _____
Relationship to person being evaluated: _____

Main Concerns (write on back of page or attach a sheet if necessary)
☐ Additional notes on back ☐ see attached sheet

_____
_____
_____
_____
_____
_____
_____

Does child have any behavioral problems?

_____
_____
_____

Does child have any school problems, besides those listed in Main Concerns?

_____
_____

Please describe child's strengths:

_____
_____
_____
_____

Please describe child's weaknesses:

_____
_____
_____
_____

FAMILY HISTORY

Please list as appropriate

	Age
This Child	
◯ Brother or Sister ◯	
◯ Brother or Sister ◯	
◯ Brother or Sister ◯	
◯ Brother or Sister ◯	

Is this child: ☐ Biological ☐ Adopted ☐ A Foster Child ☐ Other Family Member: _____

With whom does child live at the present time? *(Include parents, brothers, sisters, grandparents, other relatives, friends, etc.)*

_____

_____

Please describe marital status/custody: _____

What language(s) is used in the home? _____

Parent 1 (Mother/Father) education? _____ occupation? _____

Parent 2 (Mother/Father) education? _____ occupation? _____

Please list anybody in the child's family who is left-handed or mixed-handed:

_____

Has child or anyone else in immediate family had problems in these areas:

Problem	Person	Problem	Person
ADHD		Bipolar Disorder	
Specific Learning Disability		Schizophrenia	
Autism Spectrum Disorder		Seizures/Epilepsy	
Speech/Language Problems		Tics or Tourette's	
Dyslexia		Other (specify)	
Anxiety		Other (specify)	
Depression			
Obsessive Compulsive Disorder		Other (specify)	
Oppositional Defiant Disorder			

BIRTH HISTORY

Did the doctor note any problems with the mother's pregnancy? labor? delivery?

_____

_____

Which (1st, 2nd, 3rd, etc.) was this child of the mother's pregnancies? _____

Was child full-term? ☐ Yes ☐ No If no, how many weeks gestation?_____

Age of biological mother at delivery? _____ Age of biological father at delivery? _____

Did child require special care nursery or intensive care intervention upon birth? ☐ Yes ☐ No

If yes, please describe:_____

Birth weight:_____ Apgar score (if known):_____

Exposure to alcohol or drugs in utero? ☐Yes ☐No If yes, what substance: _____

MEDICAL HISTORY (CHILD)

Please answer the following questions about child's medical history:		
Has child had any of the following:		
Seizures or convulsions?	☐ Yes ☐ No	If yes, what age:
Serious illness?	☐ Yes ☐ No	If yes, what: At what age: For how long:
Hospitalization(s)?	☐ Yes ☐ No	If yes, why: At what age: For how long:
Surgery?	☐ Yes ☐ No	If yes, what age: What type:
Head injury/concussion? If yes, did child have a CT or MRI?	☐ Yes ☐ No ☐ Yes ☐ No	What age: What happened: What were findings:
Exposure to neurotoxins during childhood (e.g., lead, mercury, etc.)?	☐ Yes ☐ No	If yes, what age: What substance:
Does child have any of the following:		
Allergies?	☐ Yes ☐ No	
Abdominal pain/vomiting?	☐ Yes ☐ No	If yes, when does this occur:
Headaches?	☐ Yes ☐ No	If yes, how are they treated:
Vision problems?	☐ Yes ☐ No	
Hearing problems?	☐ Yes ☐ No	
A history of frequent ear infections?	☐ Yes ☐ No	If yes, how often:

Please list all of the medications child takes (including past trials):

_____

_____

_____

Has child had any sleeping difficulties? _____

Has child had any eating difficulties? _____

DEVELOPMENTAL HISTORY

Did you have any concerns about child's early developmental milestones? _____

_____

Did child have Early Intervention? _____

Please indicate the age at which child reached the following developmental milestones (if known):

Developmental Skill	**Approximate Age**
Crawled	
Walked	
Spoke first words	
Said simple phrases	
Spoke in sentences	
Followed simple instructions	
Toilet trained, day	
Toilet trained, night	

Which hand does child prefer? _____ for writing? _____ for sports? _____

At what age did child show a clear hand preference? _____

Has child ever had speech/language therapy? ☐ Yes ☐ No If yes, please answer the following:

Dates: _____ Name of Provider: _____ *Please submit any evaluations*

Has child ever had occupational/physical therapy? ☐ Yes ☐ No If yes, please answer the following:

Dates: _____ Name of Provider: _____ *Please submit any evaluations*

SOCIAL/EMOTIONAL

Has child had difficulty in separating? ☐ Yes ☐ No If yes, at what age? _____

Does child play with older, younger or same age children? _____

Does child have the opportunity to play with children of the same age outside of school? _____

Has a school or teaching professional ever raised concerns about Autism?_____

Has child displayed behavior that you've found unusual? ☐ Yes ☐ No If yes, please explain: _____

Do you have concerns regarding child's sensory processing? ☐ Yes ☐ No If yes, please explain: _____

Has child ever had psychotherapy/counseling? ☐ Yes ☐ No If yes, please answer the following:

Dates: _____ Name of Provider:_____ *Please submit any evaluations*

Do you have any concerns about substance use? ☐ Yes ☐ No

If yes, please describe: _____

SCHOOL HISTORY

What grade is child presently in? ____ Has he/she ever repeated a grade? ☐ Yes ☐ No If yes, which - ___

What schooling, if any, did child have prior to first grade? (please specify) _____

_____

Did child have pre-kindergarten screening? _____

If yes, did he/she pass? ☐ Yes ☐ No _____

In which grade did school problems become noticeable? (as appropriate) _____

What services have been provided? _____

Does child have an Individualized Education Program(IEP)? ☐ Yes ☐ No

Does child have a 504 Plan? ☐ Yes ☐ No

Does child have resource room support? ☐ Yes ☐ No If yes, how often? _____

For which academic skills? _____

Does child receive informal accommodations and/or services (e.g. Title 1, Response to Intervention)?_____

Has child had a frequent change of school(s)? ☐ Yes ☐ No If yes, describe:_____

_____

What is child's present school? (please give full address)

School Name: _____

Street: _____

City: _____ State _____ Zip: _____

Who is the appropriate contact person for details of child's school work? _____

_____

Parent/Caregiver 1 contact information

Full name: _____ Relationship to child: _____

Mailing address: _____

_____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Preferred phone: ☐ Home ☐ Cell ☐ Other Best time to call:

_____

Email address:_____

Parent/Caregiver 2 contact information

Full name: _____Relationship to child: _____

Mailing address (☐ Same as above):_____

_____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Preferred phone: ☐ Home ☐ Cell ☐ Other Best time to call:

_____

Email address:_____