Guiding Exceptional Parents

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Riverdale Park, MD 20737
301-768-8503

GETTING STARTED

To begin a thorough assessment, first, I need a few things:

- I appreciate the time that you will spend completing the **parent questionnaire**. Simply leave blank any items that you are not able to answer or that are not appropriate for your child's age.
- Please provide **copies of reports from any other professionals**.

You can send everything by email (preferred) or US mail - or just drop a package at my home office. Please let me know if you have any questions.

Thank you for giving me the opportunity to work with you and your child.

Sincerely,

Sarah C. Wayland, Ph.D.
Special Needs Care Navigator
Relationship Development Intervention (RDI) Certified Consultant

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## *Parent Questionnaire*

Today's date: _____

Child's full name: _____

Prefers to be called: _____

Birth date: _____ Age: _____

Sex: Male/Female (circle one)

Home address: _____ Zip _____

Mailing address: _____ Zip _____

Parent/ guardian (A) name: _____

Home phone: _____Work phone: _____

Cell phone: _____

Preferred phone for contact?
M-F, 9am – 5pm (check one) __Home __Work __Cell
Evenings after 5pm & weekends (check one) __Home __Work __Cell

Email: _____

Parent/ guardian (B) name: _____

Home phone: _____Work phone: _____

Cell phone: _____

Preferred phone for contact?
M-F, 9am – 5pm (check one) __Home __Work __Cell
Evenings after 5pm & weekends (check one) __Home __Work __Cell

Email: _____

Whose idea was it to have this evaluation? _____

Were you specifically referred by someone? Yes/ No

Whom: _____

Address: _____

Phone: _____

**Your Child**

Please list your child's strengths, abilities, and interests:

_____

_____

_____

_____

**Reasons for Assessment**:

What specific problems would you like help with?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## TESTING – PREVIOUS EVALUATIONS AND TREATMENTS

Please indicate if your child has had any of the following, and attach any relevant reports:

**SCHOOL TESTING** (such as an IEP evaluation, speech/language testing, OLSAT, etc.)?

| **Year** | **Grade** | **Type of Testing** (IQ, Language, OT, PT, SLP, educational, etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**OTHER EVALUATIONS** including psychologist, neurologist or other specialist doctors?

| **Year** | **Professional's Name** | **Type of Testing** | **Diagnoses? (Please list)** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICAL TESTS** including EEG, MRI, Chromosome test, etc.?

| Year | Type of Testing | Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**PAST TREATMENT**

Include diets, medications, psychological counseling, psychiatric help, tutoring, speech-language therapy, occupational therapy, physical therapy, alternative therapy, other.

| *Treatment/Reason/ Provider* | *How often?* | *Approximate dates* |
|---|---|---|

1. _____ _____ _____
_____
2. _____ _____ _____
_____
3. _____ _____ _____
_____
4. _____ _____ _____
_____
5. _____ _____ _____
_____

Any plans for changing treatments or adding new ones?

_____
_____
_____
_____
_____

## FAMILY HISTORY

Parent/ guardian (A) Age: _____ Relationship: _____ Years of education: _____
Place of employment:_____
Type of employment:_____

Parent/ guardian (B) Age: _____ Relationship: _____ Years of education: _____
Place of employment:_____
Type of employment;_____

Is child adopted? Yes/No? If yes, age when adopted:_____ Country of origin:_____
Are parents separated?_____ divorced? _____ deceased? _____ If so, child lives mainly with:
_____

If parents live separately, please describe current custody, visitation:
_____
_____
_____
Principal language spoken at home:
_____
Other languages and frequency of usage:
_____

***Please list all other children in the family***:

| Name | Age | School grade |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

***Please list any others living in the child's home***:

| Name | Age | Relationship to child |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Family Medical History Inventory**

*Other than the child for whom you are seeking this consultation, please check if there has ever been concern about any of the following in the family. Write on the line how the affected family member is related to your child (e.g. mother, father, sister, brother, paternal or maternal uncle, grandparent, etc.)*

__ Problems with hyperactivity, impulsivity, or attention deficits as a child _____

__ Trouble with reading or math, other learning disability_____

__ Kept back a grade in school_____

__ Failed to graduate high school_____

__ Speech problems_____

__ Mental retardation_____

__ Autism (PDD, Asperger's, autism) _____

__ Developmental disorder or delay_____

__ Seizures_____

__ Behavior problems in childhood or adolescence_____

__ In trouble with law: assaults, thefts, arrests_____

__ Physical abuse or sexual abuse_____

__ Depression/ suicide_____

__ Anxiety_____

__ Obsessive-compulsive behavior_____

__ Tics or Tourette's Syndrome_____

__ Drinking /Drug problem_____

__ Other significant physical or mental illness. Please describe:

_____

_____

Is there anyone in the family who had or has problems like your child's?

_____

## MEDICAL HISTORY

Child's primary physician: _____

Physician's address: _____

Physician's telephone number: _____

***Pregnancy, Delivery and Newborn History***

Mother's age when child was born: _____ Birthweight: _____

Length of pregnancy (e.g. full term, 38 weeks, etc): _____

Were there any complications during pregnancy or delivery? Yes/No (circle). If yes, please describe.

_____

_____

_____

***Childhood Medical History***

Hospitalization(s)/ Surgery:

_____

_____

_____

_____

Significant medical problems/illnesses/serious injuries.

_____

_____

_____

_____

_____

____

Allergies (food, drug, environmental):

_____

_____

_____

Date of last physical exam: _____ weight: _____ height: _____

By Dr. _____

Any problems or concerns:

_____

_____

_____

_____

***Bowel/Bladder***

Is your child toilet trained? Yes/No (circle one). Please describe any current issues with toileting:

_____

_____

_____

_____

***Sleep***

Please describe the usual bedtime routine:

_____

_____

_____

_____

_____

Trouble falling or staying asleep? Yes/No/Often/Sometimes (circle one) If Yes, Often, or Sometimes, what usually happens and how do you handle it?

_____

_____

_____

__ Very heavy sleep __ Noisy breathing or snoring during sleep

__ Trouble getting up in the morning __ Excessive naps or feels tired during the day

Wakes in the morning at what time?_____

| ***Developmental Milestones*** | **Yes** | **No** | **Too Young** |
|---|---|---|---|
| 1. Sit up by 8 months? | | | |
| 2. Crawl by 10 months? | | | |
| 3. Walk by 15 months? Age: ____ months | | | |
| 4. Speak in 2 word sentences by 2 years? | | | |
| 5. Could strangers understand your child by 3 years? | | | |
| 6. Toilet trained during the day by 3 ½ years? | | | |
| 7. Dry at night by 5 years? | | | |
| 8. Read simple words by 6 years? | | | |

| *Developmental Difficulties* | Yes | No | Too Young |
|---|---|---|---|
| 1. Urine accidents? Daytime or night time wetting? | | | |
| 2. Stool/bowel accidents (soiling)? | | | |
| 3. Difficulty falling asleep or bedtime behavior? | | | |
| 4. Difficulty staying asleep or staying in bed at night? | | | |
| 5. Difficulty waking up in the morning? | | | |
| 6. Difficulty with self-care (feeding self, washing or toileting)? | | | |
| 7. Difficulty with learning to button, zip or dress? | | | |
| 8. Difficulty learning to throw and catch a ball? | | | |
| 9. Difficulty learning to name colors or shapes? | | | |
| 10. Difficulty learning to name letters or numbers? | | | |
| 11. Difficulty learning to ride a tricycle or bicycle? | | | |

Did your child seem to develop normally but then lose developmental skills? Yes/No (circle one). If yes, describe.

_____

_____

_____

_____

_____

____

Please share anything that you feel was notable during the child's early development. How did this affect the family?

_____
_____
_____
_____
_____
_____

Has your child taken medication for attention, behavior, or emotional problems? Yes/No (circle one). If yes, please fill in the table below. .

| Medication (e.g. Focalin XR) | Dosage (e.g. 20 mg 3x day) | Date Started | Date Stopped | Effects or Adverse Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Does your child have a special diet? If so , please explain.

_____
_____
_____
_____
_____

## SCHOOL

Child's current school/daycare: _____

Grade: _____

How long has your child been at this school/daycare? _____

Contact person: _____

School/daycare address: _____

School/daycare phone: _____

School/daycare e-mail: _____

School/daycare website: _____

Approximately how many children are in your child's current classroom(s)? _____

Did your child attend any other school/preschool/nursery school in the past? Yes/No (circle one). If yes, where?

_____

_____

_____

_____

_____

Please describe the class makeup, physical space, teaching style, educational program, activities, or any other relevant details:

_____

_____

_____

_____

_____

____

Is your child in special education? Yes/No (circle) If yes, what type?

| **Placement, Programs and Services (now or in the past)** | **No** | **Yes** | **If Yes, when?** |
|---|---|---|---|
| Early Intervention Program? | | | |
| Speech Therapy? | | | |
| Occupational Therapy? | | | |
| Physical Therapy? | | | |
| Repeated a grade? If yes, which grade(s)? _____ | | | |
| Suspended from school? | | | |
| Failed or is failing a grade or subjects? | | | |
| Received any special education services? | | | |
| Placed in any special classes, program or school? | | | |
| Received resource room support or school-based tutoring? | | | |
| Received tutoring outside school? | | | |
| Received a Section 504 plan? | | | |
| Currently receiving any special education services? | | | |
| If yes, specify | | | |

Do you feel that the school currently meets your child's needs? Yes/No (circle one). If No, what needs are not being met? Future plans for school placement or special help?

_____
_____
_____
_____
_____
_____
_____

At previous daycares, preschools, or schools, were there any problems with behavior or learning? Yes/No (circle one) If yes, describe below.

_____
_____
_____
_____
_____
____

## COMMUNICATION

Is your child verbal? Yes/No/Sometimes (circle one)

If no, how does your child communicate?

_____

_____

_____

At what age did your child begin to ...

Make speech sounds? _____

Say words?_____

Say sentences?_____

Give some examples of things your child may typically say.

_____

_____

_____

_____

_____

____

Please describe concerns you have related to communication and your child.

_____

_____

_____

_____

_____

## SOCIAL FUNCTIONING

Some children behave in unusual ways. Please review the following items and indicate if they describe your child's behavior.

| Social Skills | | Not True | Somewhat True | Very True |
|---|---|---|---|---|
| 1. | Poor eye contact | | | |
| 2. | Doesn't use gestures (pointing) | | | |
| 3. | Doesn't try to use words to communicate | | | |
| 4. | Echoes words or phrases | | | |
| 5. | Speaks in unusual tone or manner | | | |
| 6. | Hard to get child's attention | | | |
| 7. | Seems preoccupied, aloof or distant | | | |
| 8. | Repetitive behaviors (flaps hands, moves body or fingers in unusual ways) | | | |
| 9. | Prefers to be alone; ignores others | | | |
| 10. | Difficulty relating to peers or making friends | | | |
| 11. | Unusual play behaviors; little pretend play | | | |
| 12. | Has unusual or very intense interests | | | |
| 13. | Takes things too literally; misses the point | | | |
| 14. | Handles change poorly; insists on sameness | | | |

How many hours per week does your child spend interacting with others? _____

How many hours per week does your child spend watching TV or playing on other electronic devices?

_____

Please list other activities and indicate amount of time spent on each.

_____

_____

Do you own a computer? Yes/No (circle one)

Does your child use a computer for school work? Yes/No (circle one)

Does your child have internet access? Yes/No (circle one)

## BEHAVIORAL FUNCTIONING

| Behavior Symptoms - A | | Never | Some-times | Often | Very Often |
|---|---|---|---|---|---|
| 1. | Makes many careless errors | | | | |
| 2. | Difficulty concentrating on difficult tasks | | | | |
| 3. | Does not seem to listen when spoken to | | | | |
| 4. | Doesn't finish tasks (such as schoolwork); Shifts from one activity to another | | | | |
| 5. | Difficulty organizing tasks or belongings | | | | |
| 6. | Avoids tasks that require concentration or effort | | | | |
| 7. | Loses or misplaces things | | | | |
| 8. | Is easily distracted by unimportant things | | | | |
| 9. | Is forgetful | | | | |
| 10. | Fidgets with hands; squirms in seat | | | | |
| 11. | Difficulty remaining seated when asked | | | | |
| 12. | Runs or climbs when told not to | | | | |
| 13. | Has difficulty playing quietly | | | | |
| 14. | Is "on the go"; Acts like "driven by a motor" | | | | |
| 15. | Talks excessively | | | | |
| 16. | Blurts out or answers questions before they have been completed; Talks before thinking; | | | | |
| 17. | Difficulty awaiting turn in groups | | | | |
| 18. | Interrupts (butts into conversations or games) | | | | |
| **19**. | Daydreams; "in his/her own world", stares blankly | | | | |
| **20**. | Does things slowly | | | | |
| **21.** | Tries his/her best | | | | |

| Behavior Symptoms – B | | Never | Some-times | Often | Very Often |
|---|---|---|---|---|---|
| 1. | Is eager to please adults | | | | |
| 2. | Loses temper | | | | |
| 3. | Argues with adults | | | | |
| 4. | Defies or refuses to do as asked | | | | |
| 5. | Deliberately annoys others | | | | |
| 6. | Blames other for own misbehavior or mistakes | | | | |
| 7. | Is touchy or easily annoyed by others | | | | |
| 8. | Is angry or resentful | | | | |
| 9. | Tries to get even or takes out anger on others | | | | |
| 10. | Is kind to others; has a "good heart" | | | | |
| 11. | Does serious lying or cheating | | | | |
| 12. | Bullies, threatens or intimidates others | | | | |
| 13. | Starts physical fights | | | | |
| 14. | Steals things | | | | |
| 15. | Deliberately destroys others' property | | | | |
| 16. | Deliberately starts fires | | | | |
| 17. | Uses a weapon when fighting (rock, stick, etc.) | | | | |
| 18. | Is mean or physically cruel to people | | | | |
| 19. | Is mean or physically cruel to animals | | | | |
| 20. | Is preoccupied with or involved in sexual activity | | | | |
| 21. | Hangs around with kids who get in trouble | | | | |

| Behavior Symptoms – C | | Never | Some-times | Often | Very Often |
|---|---|---|---|---|---|
| 1. | Is affectionate | | | | |
| 2. | Unusually sensitive hearing, sense of smell, or light sensitivity. | | | | |
| 3. | Bothered by how things feel (certain clothes, being hugged) | | | | |
| 4. | Over- or under-sensitive to pain | | | | |
| 5. | Easily over-stimulated; gets "wound up" or shuts down if too much going on | | | | |
| 6. | Unusual or limited diet | | | | |
| 7. | Hurts herself/himself on purpose? | | | | |
| 8. | History of eating things that are not food ("pica")? | | | | |
| 9. | Has strange ideas (describe below) | | | | |
| 10. | Unusual or strange behavior (describe below) | | | | |
| 11. | Lacks awareness of danger? | | | | |
| 12. | Excessive or public masturbation | | | | |
| 13. | Excessive thumb-sucking or nail-biting | | | | |
| 14. | Other habits (e.g. pulls out hair or lashes) | | | | |

Describe any concerns about behavior

_____

_____

_____

How do you usually handle misbehavior?

_____

_____

How does your child respond to being told "no" or being corrected for misbehaving?

_____

_____

Do you use physical punishment such as spanking? Yes/No (circle one). If so, how often?

_____

How does your child respond to praise, rewards or positive reinforcement?

_____

_____

Do you and your spouse or partner agree on how to handle your child's behavior? (Circle one)

*Usually Agree* *Sometimes Agree* *Rarely Agree*

EMOTIONAL HISTORY

| Emotional Symptoms | | Never | Some-times | Often | Very Often |
|---|---|---|---|---|---|
| 1. | Recovers easily from disappointments? | | | | |
| 2. | Acts too young, seems "immature"? | | | | |
| 3. | Over-reacts or easily upset? | | | | |
| 4. | Irritable or easily angered? | | | | |
| 5. | Is moody or has mood swings? | | | | |
| 6. | Has temper tantrums? | | | | |
| 7. | Has violent outbursts or prolonged rages? | | | | |
| 8. | Cries a lot? | | | | |
| 9. | Feels bad about self (low self-esteem)? | | | | |
| 10. | Unhappy, sad or depressed? | | | | |
| 11. | Low energy or tired for no reason? | | | | |
| 12. | Talks about death or suicide? | | | | |
| 13. | Enjoys many activities? | | | | |
| 14. | Worried, nervous or anxious? | | | | |
| 15. | Worries about leaving home or parents? | | | | |
| 16. | Refuses to speak except to family members? | | | | |
| 17. | Too concerned with neatness or cleanliness? | | | | |
| 18. | Unusual habits? Has to do things a certain way? | | | | |
| 19. | Can't stop worrying? (germs, doing things perfectly, family in danger, natural disasters) | | | | |
| 20. | Very self-conscious or easily embarrassed? | | | | |
| 21. | Avoids going to school? | | | | |
| 22. | Overly fearful? Specify: | | | | |

## CURRENT FUNCTIONING

Please describe your child's personality.

_____
_____
_____
_____

What are your child's strengths?

_____
_____
_____
_____

Challenges?

_____
_____
_____
_____

Please list your child's interests and favorite things.

_____
_____
_____
_____

How does your child handle separation from parents? Describe any issues with separation.

_____
_____
_____
_____
_____

Who is your child most attached to and most affectionate with? How does your child show affection to others?

_____
_____
_____
_____

Describe your child's ability to take instruction from others. Does your child show a desire to learn?

_____
_____
_____

Please describe your child's social interests. Does your child prefer to play alone or with others? When and how does your child show interest in others?

_____
_____
_____
_____

How does your child handle transitions to new people and situations?

_____
_____
_____
_____

Does your child ever initiate play with others? How?

_____
_____
_____

Are there ways to approach your child that do or do not work?

_____
_____
_____

Does your child have any interest in peers? Please describe.

_____
_____
_____

Does your child enjoy active play (playground, sports, etc)? Describe your child's interest and abilities in this area.

_____
_____
_____

Tell about your child's ability to sustain attention to an activity for a period of time.

_____
_____
_____

How does your child respond to challenges and stress?

_____
_____
_____

Does your child have any unusual behaviors? Describe.

_____
_____

Please describe a typical day for your child.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Other Family, Environmental, or Life Stresses (experienced by child)**

***Circle best answer according to current impact:***
*0= no problem; 1=little; 2=medium; 3=big problem*

FAMILY STRESSES

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Death of parent |
| *0* | *1* | *2* | *3* | Death of other family member |
| *0* | *1* | *2* | *3* | Death of pet |
| *0* | *1* | *2* | *3* | Substance abusing parent(s) |
| *0* | *1* | *2* | *3* | Physical or sexual abuse of family member |
| *0* | *1* | *2* | *3* | Mental or behavioral disorder of parent or sibling |
| *0* | *1* | *2* | *3* | Physical illness of parent or sibling |
| *0* | *1* | *2* | *3* | Addition of a sibling |
| *0* | *1* | *2* | *3* | Physical separation from primary caregiver |
| *0* | *1* | *2* | *3* | Marital discord |
| *0* | *1* | *2* | *3* | Separation/ divorce |
| *0* | *1* | *2* | *3* | Parent dating |
| *0* | *1* | *2* | *3* | Re-marriage |
| *0* | *1* | *2* | *3* | Blended family |
| *0* | *1* | *2* | *3* | Domestic violence |
| *0* | *1* | *2* | *3* | Change in primary caregiver |
| *0* | *1* | *2* | *3* | Primary caregiver does not speak language of the community |
| *0* | *1* | *2* | *3* | Parent or family member with crime problem |
| *0* | *1* | *2* | *3* | Parent underemployed |
| *0* | *1* | *2* | *3* | Parent working long hours outside the home |
| *0* | *1* | *2* | *3* | Lack of support from extended family |
| *0* | *1* | *2* | *3* | Taboo subjects (e.g., money, certain behaviors, family relationships) |
| *0* | *1* | *2* | *3* | Illiteracy of parent |

CHILD'S PERSONAL STRESSES

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Physical or sexual abuse |
| *0* | *1* | *2* | *3* | Neglect |
| *0* | *1* | *2* | *3* | Physical changes (e.g., weight loss or gain, acne, puberty, etc.) |
| *0* | *1* | *2* | *3* | Foster care / institutional care |
| *0* | *1* | *2* | *3* | Adoption |
| *0* | *1* | *2* | *3* | Witness to violence |
| *0* | *1* | *2* | *3* | Chronic, long term, or undiagnosed illness |
| *0* | *1* | *2* | *3* | Disability (diagnosed or undiagnosed) (list: _____) |
| *0* | *1* | *2* | *3* | Unusual interests and/or different ways of thinking |
| *0* | *1* | *2* | *3* | Performance anxiety (sports, music, pleasing parents, etc.) |
| *0* | *1* | *2* | *3* | Not enough free time |

PEER RELATIONSHIP STRESSES

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Discord with peers (e.g., bullying, exclusion, etc.) |
| *0* | *1* | *2* | *3* | No peers with shared interests |
| *0* | *1* | *2* | *3* | Loss of a good friend |
| *0* | *1* | *2* | *3* | Social media stress |
| *0* | *1* | *2* | *3* | Worry about friends who are struggling |

COMMUNITY STRESSES

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Adjustment to a new and different culture |
| *0* | *1* | *2* | *3* | Social discrimination or isolation of family from community |
| *0* | *1* | *2* | *3* | Religious or spiritual problem |

EDUCATIONAL STRESSES

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Inadequate school facilities |
| *0* | *1* | *2* | *3* | New school and/or new teacher (circle) |
| *0* | *1* | *2* | *3* | Does not get along with teacher(s) |
| *0* | *1* | *2* | *3* | Does not get along with classmates |
| *0* | *1* | *2* | *3* | Unexpected change to teacher or classroom (circle) |
| *0* | *1* | *2* | *3* | Poor academic performance (Which class(es)? _____) |
| *0* | *1* | *2* | *3* | Too much schoolwork |
| *0* | *1* | *2* | *3* | Too much homework |
| *0* | *1* | *2* | *3* | Undiagnosed/unrecognized/unsupported disability |

*INADEQUATE RESOURCES*

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Food insecurity/lack of adequate nutrition |
| *0* | *1* | *2* | *3* | Homelessness or uncertain housing |
| *0* | *1* | *2* | *3* | Financial instability |
| *0* | *1* | *2* | *3* | Lack of adequate health care |

ENVIRONMENTAL STRESSES

| | | | | |
|---|---|---|---|---|
| *0* | *1* | *2* | *3* | Unsafe neighborhood |
| *0* | *1* | *2* | *3* | New school |
| *0* | *1* | *2* | *3* | Long trip (e.g., vacation) |
| *0* | *1* | *2* | *3* | Big celebration (birthdays, communion, bar/bat mitzvahs, weddings, etc.) |
| *0* | *1* | *2* | *3* | Unexpected changes (unannounced change in plans, teacher, etc.) |
| *0* | *1* | *2* | *3* | Uncertainty (not knowing what will happen) |
| *0* | *1* | *2* | *3* | Dealing with relatives |
| *0* | *1* | *2* | *3* | Exposure to upsetting news stories |
| *0* | *1* | *2* | *3* | Natural disaster |