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New Client Questionnaire

Confidential and Privileged Information

Your efforts to complete this questionnaire are appreciated. This information is important and needed for Dr. Kaeppner to determine how to best serve your child. Answer all questions to the best of your ability.

IDENTIFYING INFORMATION **Today's Date:** _____

Child's Name: _____
First Middle Last

Name Child Prefers: _____ Birthdate: _____ Sex: _____

Race: [ ] Caucasion [ ] African-American [ ] Hispanic [ ] Asian [ ] Other: _____

With whom does the child live: _____

Address: _____

City: _____ State: _____ County: _____ Zip Code: _____

Telephone: (____) _____ Relationship to Child: _____

Legal Guardian/Caseworker (if other than parent): _____

Address: _____ City: _____ State: _____ County: _____ Zip Code: _____

Telephone: (____) _____ Relationship to Child: _____

Alternate Contact Name: _____ Alternate Telephone: (____) _____

Person Completing this Form: _____ Relationship to Child: _____

PRESENTING ISSUES

What are you concerned or worried about? _____

_____

_____

_____

What do you hope to learn from this evaluation? _____

_____

_____

_____

How old do you think your child acts?

	Younger	At Age Level	Older
Socially			
Academic / School Skills			
Mental Ability			
Physical Abilities / Coordination			
Self-Care / Daily Responsibilities			
Speech / Language			

List your child's strengths or good points. _____

_____

Describe how your child communicates. _____

_____

How does your child interact with other children at home and at other places including school? _____

_____

_____

What are your child's favorite activities? _____

_____

How does your child act when angry or upset? _____

_____

Do you have any concerns about how your child walks, eats or uses his or her hands? _____

_____

Do you have any vision or hearing concerns? _____

_____

Any other comments or concerns in your child's development or behavior? _____

_____

_____

EDUCATIONAL HISTORY (Please complete for all children enrolled in school)

Grade: _____ Present Teacher: _____ Principal: _____

School child is attending now: _____ School District: _____

School Street Address: _____

School City, State and Zip Code: _____

Telephone: (_____) _____

Has this child had a school evaluation for learning issues? _____ Yes _____ No _____ Not Sure

(Please remember to bring or send all school reports.)

School Placements and Services. Check all that apply:

[ ] Regular Class
[ ] Speech Therapy – How often? _____
[ ] Occupational Therapy – How often? _____
[ ] Physical Therapy = How often? _____
[ ] Resource Room
[ ] Special Educator
[ ] Classroom Aide
[ ] Inclusion Class
[ ] Tutor
[ ] After School Programming
[ ] Remedial Instruction
[ ] Transportation
[ ] Individual Education Plan (IEP)

Is your child on grade level for:

Reading	[ ] Yes	[ ] No
Writing	[ ] Yes	[ ] No
Mathematics	[ ] Yes	[ ] No

Please comment on any other aspect of your child in school which concerns you.

_____

_____

_____

FAMILY INFORMATION

MOTHER:
Name: _____ Date of Birth: _____
First Last Maiden
List any physical health, mental health, or learning problems: _____

What was the highest school grade / level completed? _____ At what age? _____

Occupation: _____
Employed outside the home: [ ] Yes [ ] No [ ] Full time [ ] Part time

FATHER:
Name: _____ Date of Birth: _____
First Last Maiden
List any physical health, mental health, or learning problems: _____

What was the highest school grade / level completed? _____ At what age? _____

Occupation: _____
Employed outside the home: [ ] Yes [ ] No [ ] Full time [ ] Part time

Check whether this child's parents are: [ ] Married [ ] Single [ ] Separated [ ] Divorced

Are this child's parents living together? [ ] Yes [ ] No

Is either parent deceased? [ ] No [ ] Yes, Mother [ ] Yes, Father

Is there a stepparent in this child's home? [ ] Yes [ ] No

If yes, please complete:
Name: _____ Age: _____

The relationship of this child to this household is: [ ] Biological [ ] Foster [ ] Adopted [ ] Other _____

If in foster case:

How many previous foster placement? _____

Names of foster case agency and caseworker. _____

How long has this child been in this household? _____

List all brothers and sisters, indicate whether full, half, step or adopted, and their ages.

Name:	Age:	Name:	Age:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all members of this child's household:

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

PREGNANCY HISTORY;

Age of mother at the time of this child's birth: _____

Total number of pregnancies for the child's mother: _____

Has this child's mother had any miscarriages? [ ] Yes [ ] No

Check all that apply for the mother and the pregnancy of this child:

[ ] Needed medications	[ ] Diabetes	[ ] High blood pressure	[ ] Poor weight gain
[ ] Fever or infection	[ ] Pre-term labor	[ ] Smoked cigarettes	[ ] Toxemia
[ ] Abnormal ultrasound	[ ] Amniocentesis	[ ] No medical care	

[ ] Exposure to cocaine, crack, marijuana, speed or other recreational drugs; specify _____

[ ] Drank beer, wine or other forms of alcoholic beverages

Any other comments about the pregnancy with this child: _____

_____

BIRTH HISTORY

Birth weight: _____ pounds _____ ounces
Birth length: _____ inches

Check all that apply for the birth of this child:

[ ] Born at term	[ ] Natural (vaginal) delivery	[ ] Feeding problems
[ ] Premature	[ ] Cesarean section	[ ] Weight problems
[ ] Multiple births (twins, triplets)	[ ] Forceps or suction needed	[ ] Jaundice
[ ] Special care nursery	[ ] Needed oxygen	[ ] Infection
[ ] NICU	[ ] Breathing problems	[ ] Seizures

Any comments about the delivery or baby's first month: _____

_____

DEVELOPMENTAL MILESTONES

Choose one: [ ] There was a concern about delays
or
[ ] Development generally seemed typical

At what age did the child:

_____ Sit without support _____ Said mama and dada with meaning

_____ Crawl _____ Said single words

_____ Walk _____ Say two word phrases

PAST MEDICAL HISTORY

List any hospitalizations, surgeries and chronic medical conditions: _____

_____

_____

List current or significant past medications: _____

_____

_____

Are immunizations up to date? [ ] Yes [ ] No

REFERENCES OR PREVIOUS STUDIES

Child's Hospitalizations or Specialists seen:

Hospital or Clinic Name: _____

Address: _____

City, State, Zip Code: _____

[ ] EEG [ ] CT Scan [ ] MRI [ ] X-rays [ ] Chromosomes [ ] Lab Studies

Where: _____ Where: _____

[ ] Psychological Testing [ ] Occupational Therapy

Where: _____ Where: _____

[ ] Audiology – Hearing Testing [ ] Phsyical Therapy

Where: _____ Where: _____

[ ] Speech Evaluation or Therapy [ ] Behavioral or Psychological Counseling

Where: _____ Where: _____

[ ] Social Services Agency [ ] Other _____

Where: _____ Where: _____

In the table below, put a check in the box that indicates which illness or problem pertains to child, brothers, sisters, parents or other family members.

ILLNESS OR PROBLEM	*BROTHERS & SISTERS*	*PARENTS OF CHILD*		*OTHER FAMILY MEMBERS (specify)*
		Mother	*Father*	
Language, needed speech therapy				
Learning, needed help in school				
Mental retardation				
Attention Deficit Hyperactivity Disorder (ADHD)				
Behavior Problems				
Autism/Pervasive Development Disorder (PDD)				
Seizures				
Muscular Dystrophy, Motor Diseases, Cerebral Palsy				
Depression, Manic-Depression, Schizophrenia, Nerves, Panic Attacks, Anxiety				
Physical or Sexual Abuse				
Alcoholism, Drug Use				
Deafness				
Blindness				
Asthma, Lung Problems, Heart Problems, Stomach or Intestine Problems, Kidney Problems				
Condition Similar to This Child				