Health Concern Evaluation - Parent Questionnaire

Today's Date: ___/___/___
Child's Name: _____ Age: _____ DOB: ___/___/___
Parent's Name: _____ Phone: (___)_____

Siblings: Name Age Medical, Social, Academic, Speech Problems

_____

_____

_____

What questions would you like to have answered when the evaluation is complete?

1) _____
2) _____
3) _____

Whose idea was it that the child have an evaluation? _____

Current School Placement (incl teacher's name, grade, classroom type, testing):

_____

_____

What do you feel are the strengths of your child?

_____

_____

_____

_____

Specifically, what does your child enjoy and/or dislike about school?

_____

_____

_____

_____

Has your child received any special treatments (psychological counseling, psychiatric help, etc.)? If yes, please describe:

_____

_____

_____

_____

FAMILY HISTORY for Health Concern Evaluation

Language spoken at home (circle): English Spanish Other _____

Mother
Age_____
Occupation_____
Highest Grade Completed_____

Father
Age_____
Occupation_____
Highest Grade Completed_____

Any history of:
- ☐ learning problems
- ☐ speech problems
- ☐ behavior problems
- ☐ medical problems
- ☐ emotional problems
- ☐ drug or alcohol abuse

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- ☐ learning problems
- ☐ speech problems
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- ☐ medical problems
- ☐ emotional problems
- ☐ drug or alcohol abuse

Parents are:
- ☐ married
- ☐ living together
- ☐ separated
- ☐ divorced
- ☐ mother deceased
- ☐ father deceased

Child lives with:
- ☐ both parents
- ☐ mother
- ☐ father
- ☐ other _____

Please list any relatives on either side of the family who have had the following (if more than one person, please note)

Family History of:	Relationship to child	Mother's side	Father's side
Behavior problems, hyperactivity			
Drug or alcohol abuse			
Emotional problems, ie depression			
Learning problems			
Speech problems			
Ambidexterity, or left hand preference			
Migraine headaches			
Mental retardation			
Childhood diabetes			
Colitis			
Lupus erythematosis			
Rheumatoid arthritis			
Thyroid disease			

NICHQ Vanderbilt Assessment Scale: Parent Informant

Today's Date: _____

Child's Name: _____

Child's Date of Birth: _____

Parent's Name: _____

Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child

☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework				
2. Has difficulty keeping attention to what needs to be done				
3. Does not seem to listen when spoken to directly				
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)				
5. Has difficulty organizing tasks and activities				
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort				
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)				
8. Is easily distracted by noises or other stimuli				
9. Is forgetful in daily activities				

For Office Use Only _____/9

10. Fidgets with hands or feet or squirms in seat				
11. Leaves seat when remaining seated is expected				
12. Runs about or climbs too much when remaining seated is expected				
13. Has difficulty playing or beginning quiet play activities				
14. Is "on the go" or often acts as if "driven by a motor"				
15. Talks too much				
16. Blurts out answers before questions have been completed				
17. Has difficulty waiting his or her turn				
18. Interrupts or intrudes in on others' conversations and/or activities				

For Office Use Only _____/9

NICHQ Vanderbilt Assessment Scale: Parent Informant

Symptoms (continued)	Never	Occasionally	Often	Very Often	
19. Argues with adults					
20. Loses temper					
21. Actively defies or refuses to go along with adults' requests or rules					
22. Deliberately annoys people					
23. Blames others for his or her mistakes or misbehaviors					
24. Is touchy or easily annoyed by others					
25. Is angry or resentful					
26. Is spiteful and wants to get even					For Office Use Only /8
27. Bullies, threatens, or intimidates others					
28. Starts physical fights					
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)					
30. Is truant from school (skips school) without permission					
31. Is physically cruel to people					
32. Has stolen things that have value					
33. Deliberately destroys others' property					
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)					
35. Is physically cruel to animals					
36. Has deliberately set fires to cause damage					
37. Has broken into someone else's home, business, or car					
38. Has stayed out at night without permission					
39. Has run away from home overnight					
40. Has forced someone into sexual activity					For Office Use Only /14
41. Is fearful, anxious, or worried					
42. Is afraid to try new things for fear of making mistakes					
43. Feels worthless or inferior					
44. Blames self for problems, feels guilty					
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"					
46. Is sad, unhappy, or depressed					
47. Is self-conscious or easily embarrassed					For Office Use Only /7

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic	
48. Reading						
49. Writing						For Office Use Only 4s /3
50. Mathematics						For Office Use Only 5s /3
51. Relationship with parents						
52. Relationship with siblings						
53. Relationship with peers						For Office Use Only 4s /4
54. Participation in organized activities (eg, teams)						For Office Use Only 5s /4

Other Conditions

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

1. **Motor Tics:** Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, or rapid kicks.

   ☐ No tics present. ☐ Yes, they occur nearly every day but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.

2. **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, or repetition of words or short phrases.

   ☐ No tics present. ☐ Yes, they occur nearly every day but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.

3. If **YES** to 1 or 2, do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)? ☐ No ☐ Yes

Previous Diagnosis and Treatment: To the best of your knowledge, please answer the following questions:

1.	Has your child been diagnosed with a tic disorder or Tourette syndrome?	☐ No	☐ Yes
2.	Is your child on medication for a tic disorder or Tourette syndrome?	☐ No	☐ Yes
3.	Has your child been diagnosed with depression?	☐ No	☐ Yes
4.	Is your child on medication for depression?	☐ No	☐ Yes
5.	Has your child been diagnosed with an anxiety disorder?	☐ No	☐ Yes
6.	Is your child on medication for an anxiety disorder?	☐ No	☐ Yes
7.	Has your child been diagnosed with a learning or language disorder?	☐ No	☐ Yes

Comments: