Pryor & Associates Counseling
and Diagnostic Center

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DESOTO, TEXAS 75115

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PARENT QUESTIONNAIRE

Student's name: _____ **Relationship to Student** _____

Child's Present School: _____ **Grade:** _____

Name of Public School District: _____

City, State, and Country Where Child was Born: _____

Medications Your Child Currently Takes: _____

Check any of the following that are true of this child and provide details requested:

☐ **Child is adopted** At what age? _____ ☐ **Child is a foster child** At what age? _____

Reason child is adopted or in foster care: _____

Parents are: ☐**Married** ☐ **Separated** ☐ **Divorced** ☐ **Single** ☐ **Mother deceased** ☐**Father deseased**

Child lives mainly with: ☐ **Mother** ☐ **Stepmother** ☐ **Father** ☐ **Stepfather** ☐ **Other – Specify** _____

Provide the following information for each family member:

	Age	Education	Current Occupation	Current Employer	General Health
Father					
Mother					
Stepfather					
Stepmother					
Others					

Brother(s): Age(s) _____

Sister(s): Age(s) _____

Have any of the child's *biological* family members ever been diagnosed with the following? (Check the box beside all who have):

ADHD/ADD/Hyperactive		☐FATHER		☐MOTHER		☐BROTHER		☐SISTER		☐OTHER:_____
Learning Disability		☐FATHER		☐MOTHER		☐BROTHER		☐SISTER		☐OTHER:_____
Dyslexia		☐FATHER		☐MOTHER		☐BROTHER		☐SISTER		☐OTHER:_____
Emotional Problems		☐FATHER		☐MOTHER		☐BROTHER		☐SISTER		☐OTHER:_____
Specify:_____		☐FATHER		☐MOTHER		☐BROTHER		☐SISTER		☐OTHER:_____

What do you want to know from this evaluation? Please list the problems with which you want help for this student.

1. _____

2. _____

3. _____

4. _____

What have you said to him/her about this evaluation?: _____

Who referred you for this evaluation?: _____

If so, whom: Name _____ **Address** _____

For what reason? _____

How do you plan to use the information from this evaluation? _____

List *ALL* previous educational or psychological evaluations your child has had.

Age and Grade	School or Provider Name and Location	Why was your child evaluated?	What help did your child get after this evaluation?

ATTACH A PHOTOCOPY OF ANY REPORTS NOT ALREADY PROVIDED.

Has this student received any special treatments (speech therapy, diets, medications, psychological counseling, psychiatric help, etc.) outside of school? ☐ **YES** ☐ **NO**

If so, please describe below.

Approximate Date(s)	**Type(s) of Treatment** *(include name of any medication you remember)*

Please attach a recent photograph of the student, if available, in the space below. This will help us remember him or her if there is an inquiry from you after the evaluation. It is not essential, but it can be very useful. Any size is acceptable. If one is not available, by signing below, you are giving us permission to take a photograph while he/she is in our center. This photograph will only be used for the purposes described above.

QUESTIONS ABOUT YOUR CHILD'S LANGUAGE AND LEARNING

Read each sentence and circle how often the problem occurs or occurred:

1.	My child has/had trouble producing specific speech sounds.	Rarely	Often
2.	My child cannot saying words with difficult speech patterns (conditioner)	Rarely	Often
3.	My child confuses similar sounding words (specific, Pacific)	Rarely	Often
4.	My child shows frequent slips of the tongue. (The "entire" state building.)	Rarely	Often

5.	My child uses incorrect grammar.	Rarely	Often
6.	My child says sentences with words in the wrong order.	Rarely	Often
7.	My child's sentences do not sound like other children his/her age.	Rarely	Often
8.	My child has trouble understanding questions or spoken directions.	Rarely	Often
9.	My child only responds to part of an instruction with more than one part.	Rarely	Often
10.	My child asks me to repeat questions and/or spoken directions.	Rarely	Often

11.	My child has trouble finding the right word to say.	Rarely	Often
12.	My child's speech is hesitant, filled with pauses.	Rarely	Often
13.	My child frequently uses words that have little meaning ("thing", "stuff")	Rarely	Often
14.	My child talks a lot but gives little information.	Rarely	Often

15.	My child has difficulty looking at the person he/she is talking to.	Rarely	Often
16.	My child has trouble keeping up a conversation with friends.	Rarely	Often
17.	My child uses bad behavior (hitting) instead of words to solve problems.	Rarely	Often
18.	My child has trouble getting to the point when talking.	Rarely	Often
19.	My child has trouble telling me about a movie he/she just saw.	Rarely	Often
20.	My child has trouble telling about a recent experience.	Rarely	Often
21.	My child uses slang incorrectly or at the wrong time.	Rarely	Often
22.	My child cannot understand common expressions ("I'm sick as a dog")	Rarely	Often
23.	My child has trouble understanding jokes and riddles.	Rarely	Often
24.	My child has difficulty understanding sarcastic comments.	Rarely	Often

On the remaining items, if your child has not practiced this skill, circle the asterisk (*)

25.	**My child has/had trouble learning letter names and sounds.**	**Rarely**	**Often**	*
26.	**My child miscalls words when reading aloud.**	**Rarely**	**Often**	*
27.	**My child avoids reading aloud.**	**Rarely**	**Often**	*
28.	**My child's reading is hesitant and choppy.**	**Rarely**	**Often**	*
29.	**My child reads slowly.**	**Rarely**	**Often**	*
30.	**My child has difficulty understanding what he reads.**	**Rarely**	**Often**	*
31.	**My child has problems answering questions in textbooks.**	**Rarely**	**Often**	*

32.	**My child has/had trouble drawing shapes.**	**Rarely**	**Often**	*
33.	**My child has trouble remembering letter shapes when writing.**	**Rarely**	**Often**	*
34.	**When writing, it looks like my child is drawing the letters.**	**Rarely**	**Often**	*
35.	**My child's handwriting is slow and takes a lot of work.**	**Rarely**	**Often**	*
36.	**My child gets low grades on spelling.**	**Rarely**	**Often**	*
37.	**My child has difficulty using grammar in written work.**	**Rarely**	**Often**	*
38.	**My child's written sentences do not make sense.**	**Rarely**	**Often**	*
39.	**My child has difficulty preparing an organized written story.**	**Rarely**	**Often**	*
40.	**My child has problems answering essay questions.**	**Rarely**	**Often**	*

41.	**My child had difficulty counting and learning numbers.**	**Rarely**	**Often**	*
42.	**My child has/had trouble learning math vocabulary.**	**Rarely**	**Often**	*
43.	**My child has/had difficulty learning math symbols (+, -, etc.)**	**Rarely**	**Often**	*
44.	**My child has/had problems learning math facts.**	**Rarely**	**Often**	*

45.	**My child has/had difficulty learning to carry and borrow.**	**Rarely**	**Often**	*
46.	**My child has/had trouble solving math word problems read aloud.**	**Rarely**	**Often**	*
47.	**My child has/had difficulty solving fraction and decimal problems.**	**Rarely**	**Often**	*
48.	**My child has trouble solving algebra problems.**	**Rarely**	**Often**	*
49.	**My child has difficulty solving geometry problems.**	**Rarely**	**Often**	*
50.	**My child has trouble solving problems with graphs.**	**Rarely**	**Often**	*
51.	**My child has trouble with science and social studies**	**Rarely**	**Often**	*

Additional Information:

SCHOOL HISTORY

Schools Attended

List all the schools your child has attended. Beginning with kindergarten, list the grade, name of school (and district if public school).

Grades	School Name	Public School District Name

Which grades did your child repeat (if applicable)? _____

HOME SCHOOL HISTORY

If your child is home schooled, answer the following:

What curriculum do you use?

Reading: _____
Spelling: _____
Mathematics: _____
Science/Social Studies: _____

What is your typical daily schedule?

_____
_____
_____
_____
_____
_____
_____

Reasons why you choose to home school?

_____
_____
_____
_____
_____

Previous Education-Related Services

Record public or private education-related services by: child's age, length (e.g., 30 min.), frequency (e.g., once weekly) of each session, total time service was provided, and provider name (individual or school).

	Child's Age(s)	Total Time in Years and Months	Provider Name
Early childhood intervention (ECI,PPCD)			
Speech therapy			
Oral language therapy			
Occupational therapy			
Physical therapy			
Adaptive PE			

If your child has attended summer school, tell when (grade) and what subjects were studied.

Grade Level	Subjects studied during summer school:

Previous Reading Support

Record any previous reading support (reading recovery, Title I reading, learning lab, accelerated reading, school dyslexia program, or private therapist). Include the name of the curriculum.
If dyslexia therapy was provided privately, also list therapist's name under method.

Grade	Type of Help /Curriculum Name	How did reading improve?	Frequency
			____hours per week for___ wks.
			____ hours per week for____wks.
			____ hours per week for____wks.
			____ hours per week for___ wks.

Special Education

Have you attended an Admission, Review, and Dismissal meeting (ARD)? ☐ Yes ☐No
Record special education services provided by grade, subject area, and type of help provided.

Grade	Subject Area	Type of Help Provided (resource or content mastery)

Grades

Record or attach your child's grades during the current or most recent grading period in:

Spelling:_____

Reading:_____

Language art (ELAR)s:_____

Math:_____

Content Classes:_____

Use of Technology for Learning

Does your child currently use a computer for school work?	☐ Yes	☐ No
Does your family currently have a computer your child can use?	☐ Yes	☐ No
Do you plan to purchase a computer for your child in the future?	☐ Yes	☐ No

What type of computer does your family own?_____

Check items your computer has: ☐ CD-Rom ☐ Internet Access ☐ DVD Player

What other technology is available to your child **at home?:** _____

What technology is available to your child **at school?:** _____

MEDICAL HISTORY

Put a (✓) in the appropriate column following each item.

PREGNANCY HISTORY	TRUE	NOT TRUE	CANNOT SAY
Had bleeding during pregnancy (Which month? _____)			
Gained Less Than 15 lbs. or More Than 30 lbs. -- Specify weight gain:_____			
Took prescribed medications -- Specify: _____			
Took narcotic drugs -- Specify:_____			
Drank alcoholic beverages -- Amount: _____			
Had an infection -- specify: _____			
Smoked a pack (or more) of cigarettes a day.			
Had a Cesarean Section -- Reason:_____			
Required special procedures during the delivery -- Specify:_____			
Had a difficult delivery			
Was put to sleep for delivery			
Labor lasted less than two hours			
Other pregnancy problems:_____			

Length of pregnancy _____ months Baby's birth weight _____lbs. _____ounces

Check if this child is a ☐ Twin ☐ Multiple Specify: _____

Put a (√) in the appropriate column following each item:

NEWBORN INFANT HISTORY	TRUE	NOT TRUE	CANNOT SAY
Newborn stayed in hospital more than 48 hours. Length of newborn baby's hospital stay:_____			
Stayed in hospital with mother during her recovery. Length of mother's hospital stay: _____			
Needed oxygen -- How long? _____			
Required Intensive Care -- Why? _____			
Was treated for jaundice -- Type of treatment:_____			
Had seizures (fits, convulsions)			
Required a special monitor at home. How many months? _____			
Born with congenital defects -- Specify:_____			
Other newborn problems -- Specify: _____			
Was given medications			
Had skin problems			

Put a (√) in the appropriate column following each item. If not applicable, leave blank.

	AGE in MONTHS			YEARS (specify age in appropriate column)				
	0-3	4-8	9-12	1-2	3-5	6-9	10-12	13-15
Glasses prescribed								
Other Eye Problems								
Hearing aide needed								
Ear infections								
Seasonal Allergies								
Food Allergies								
Asthma								
Pneumonia								
Slow weight gain								
Excess weight gain								
Stomach problems								
Bed wetting								
Urinary Tract Problem								
Anemia								
Heart Problems								
Poisoning / Overdose								
Lead Poisoning								
Other poisoning/overdose								
Traumatic Brain Injury								
Seizures / Spells								
Meningitis								

Heart Problems								

Hospital Visits / Surgery	**Child's Age**	**Reason for Hospitalization or Surgery**
Emergency Room Visits		
Admitted to Hospital		
Admitted to Intensive Care		
Surgeries		

INJURIES	**Approximate Ages / Cause of Injury / Medical Treatment**
Cuts requiring stitches	
Broken bones	
Almost Drowned	
Head injury	
Concussion	
Other:	

Name of Medication Prescribed on a Regular or Daily Basis.	Dose size and number of times given per day	Date started	Date Stopped	Benefits	Side effects

Were there medications that did not help? If so, why not?:

What type of physician currently prescribes your child's medication? (check appropriate box):

☐ pediatrician ☐ family practitioner ☐ psychiatrist ☐ other:_____

ALLERGIC REACTION TO MEDICATION OR LATEX

Has your child has ever had an allergic reaction to medication or latex? ☐ YES ☐ NO

Medication or Latex	Reaction (breathing problems, swelling, hives, rash, itching)

DEVELOPMENTAL HISTORY

Indicate the specific age in months when these developmental milestones first occurred.

EARLY DEVELOPMENT	SPECIFY AGE IN MONTHS
Sat up without help	
Crawled	
Walked alone (10-15 steps)	
Spoke first words (Mama, Dada, etc.)	
Put two words together (Mama go, want cookie, drink juice)	
Spoke 2-3 word sentences	
Used finger to feed self	

Put a (√) next to each item under the column, giving the age at which this "milestone" first occurred. If there are skills your child still cannot do, leave the columns blank.

LATER DEVELOPMENT	YEARS					
	2	3	4	5	6	7+
Spoke clearly so strangers understood						
Fully bladder trained for daytime						
Fully bladder trained for nighttime						
Able to dress self						
Rode a bicycle (without training wheels)						
Able to tie shoelaces						

FAMILY HISTORY

List people who live in the same home as your child:_____
If any of those people have poor health, describe the problem:_____

For *biological parents*, put a (√) in the box if statement is true. For other family members, indicate relationship.

FAMILY HISTORY	CHILD'S MOTHER	CHILD'S FATHER	CHILD'S BROTHER(S)	CHILD'S SISTER(S)	OTHERS (SPECIFY)
tention problems					
ouble learning to read					
ouble with arithmetic					
ouble with handwriting					
ouble writing stories, reports					
pt back in school					
ticulation problems or stuttering					
oblem understanding instructions					
oblem using words					
ental Retardation					
netic Disorders					
havior problems					
pression or Mood Disorder					
xiety Disorder					
her Mental Illness (specify below)					
inking problem					
ug abuse					

SOCIAL HISTORY

Check (✓) interests your child has outside of school.

- ☐ **Art**
- ☐ **Sports/athletics**
- ☐ **Skating**
- ☐ **Singing**
- ☐ **Video Games**
- ☐ **Drawing**
- ☐ **Scouting activities**
- ☐ **Biking**
- ☐ **Listening to music**
- ☐ **Internet**
- ☐ **Crafts**
- ☐ **Building projects**
- ☐ **Dance**
- ☐ **Fishing**
- ☐ **Acting/Theatre**
- ☐ **Collecting**
- ☐ **Skateboarding**
- ☐ **Gymnastics**
- ☐ **Hunting**
- ☐ **Playing an instrument**
- ☐ **Other:**_____

List 3 things your child is good at doing:
If your child participates in a structured class, sport, or other activity, give that information:

Activity Example: Football player	When Example: 3rd thru 6th grade	Where Example: School

Does your child get along with other children? ☐ Yes ☐ No

Tell why _____

Does your child have trouble making friends? ☐ Yes ☐ No

Tell why _____

Does your child have trouble keeping friends? ☐ Yes ☐ No

Tell why _____

Do your child's friends tend to be younger? ☐ Yes ☐ No

Tell why _____

Do your child's friends tend to be older? ☐ Yes ☐ No

Tell why _____

FAMILY-CHILD RELATIONS

How does this child get along with each family member?
Father:_____
Mother:_____
Siblings:_____

What activities does this child enjoy doing with family members?
Father:_____
Mother:_____
Siblings:_____

What causes bad times for this child and other family members?
Father:_____
Mother:_____
Siblings:_____

How does this child express himself or herself with family members when upset?
Father:_____
Mother:_____
Siblings:_____

What do you like about your child?_____

What do others like about your child?_____

Was child breast-fed? ☐ Yes (until age _____ months) ☐ No

Comments, if any, on child's first ten years (if appropriate)

_____

_____

Do you have concerns about discipline? ☐ Yes ☐ No

Who disciplines your child?_____

What ways to discipline are used?_____

Does discipline work? ☐ Almost Always ☐ Sometimes ☐ Rarely ☐ Never

Why? _____

Does your child have problems doing homework alone? ☐ Yes ☐ No

About how much time is spent on homework? _____ hours per day.

How often is help needed? ☐ Constant ☐ A lot ☐ Some ☐ None

What makes homework hard for your child?_____

Does your child need reminders to get ready for school? ☐ Yes ☐ No

How much help is needed? ☐ Constant ☐ A lot ☐ Some ☐ None

What makes the morning routine hard for your child?_____

Does your child have falling asleep at night? ☐ Yes ☐ No

Does your child have staying asleep at night? ☐Yes ☐ No

During the week: What time does your child go to bed?_____ PM get up? _____AM

Is your child difficult to get out of bed? ☐ Always ☐ Sometimes ☐ Never

Describe any changes in sleep:_____

Describe any behaviors your child repeats more than 4 times in a row (washing hands, counting objects, repeating words):_____

Describe any odd actions your child says he or she has to do to be safe or to prevent a problem:

_____

How often does your child worry about weight? ☐ Always ☐ Sometimes ☐ Never

Does your child say, "I'm worried about how I look?" ☐ Always ☐ Sometimes ☐ Never

How often does your child skip meals? ☐ Always ☐ Sometimes ☐ Never

How often does your child "over-eat?" ☐ Always ☐ Sometimes ☐ Never

How often does your child weigh himself or herself? Every _____days

How often does your child use diet pills? ☐ Always ☐ Sometimes ☐ Never

How often does your child use laxatives? ☐ Always ☐ Sometimes ☐ Never

Does your child become ill during or after meals? ☐ Always ☐ Sometimes ☐ Never

On average, how many hours per week does your child watch TV or videos? _____ hours

On average, how many hours per week does your child play video games? _____ hours

On average, how many hours per week does your child exercise? _____ hours

Give examples of activities (other than TV or video games) where your child plays alone or concentrates for 30 to 45 minutes: _____

Does your child smoke cigarettes or chew tobacco? ☐ Yes ☐ No

Has your child ever used illegal drugs or alcohol? ☐ Yes ☐ No
If yes, specify details:

Of your child's behaviors, what concerns you the most? _____
_____
_____
_____

Attention Control Inventory

Directions: The tables below include a series of traits that are found commonly among children and adolescents who are having problems with attention. The traits are grouped in three parts, Mental Energy Controls (needed to maintain alertness and exert effort), Processing Controls (needed to focus properly on incoming information), and Production Controls (needed to regulate work output and behavior). Each part lists traits that may be seen in children who have problems with attention. In some instances, the individual traits they affect schoolwork, behavior, or the ability to relate to other children. Please use the rating key to show which of these traits are found in this student. You can indicate whether the trait is affecting the student's schoolwork, behavior and/or social life. Squares that are shade it need not be marked. You may leave an item blank if it is not something you are in a position to observe.

Rating Key

3 = Never or Almost Never Evident
2= Occasionally Evident
1= Evident Often
0= Evident All or Almost All of the Time

	Part 1 - Mental Energy Controls	**Effects on School Work**				**Effects on Behavior**			
		0	**1**	**2**	**3**	**0**	**1**	**2**	**3**
	Has trouble staying alert								
	Attention hard to attract								
	Loses focus unless very interested								
	Has unpredictable behavior/school work								
	Shows highly inconsistent error patterns								
	Keeps "tuning in" and tuning out								
	Has trouble finishing things he/she starts								
	Has difficulty getting started with work								
	Has a hard time exerting effort/doing work								
	Yawns, stretches excessively during class								
	Has trouble getting up in the morning								
	Looks tired								

Rating Key

3 = Never or Almost Never Evident
2= Occasionally Evident
1= Evident Often
0= Evident All or Almost All of the Time

	Part 2 – Processing Controls	**Effects on School Work**				**Effects on Behavior**			
		0	**1**	**2**	**3**	**0**	**1**	**2**	**3**
	Is easily distracted by sounds								
	Focuses on unimportant information								
	Is easily distracted by visual things								
	Forgets what he/she just heard								
	Focuses too deeply at times								
	Misses important details or cues								
	Is too passive in thinking								
	Has unusual ideas or thoughts								
	Daydreams, free associates easily								
	Doesn't concentrate long enough								
	Shows even concentration								
	Has trouble shifting attention								
	Craves excitement								
	Has trouble delaying gratification								
	Gets bored easily								

Rating Key

3 = Never or Almost Never Evident
2= Occasionally Evident
1= Evident Often
0= Evident All or Almost All of the Time

	Part 3 – Production Controls	**Effects on School Work**				**Effects on Behavior**			
		0	**1**	**2**	**3**	**0**	**1**	**2**	**3**
	Doesn't think ahead before acting								
	Has trouble planning work								
	Is not prepared for what's coming next								
	Often does first thing that comes to mind								
	Does not use strategies								
	Doesn't predict effects of acts or words								
	Is over active/fidgety								
	Is disorganized with time								
	Does many things too quickly								
	Makes careless errors								
	Fails to notice when bothering others								
	Has trouble knowing how he/she's doing								
	Punishment doesn't make a difference								
	Seems not to learn from experience								
	Keeps making same kinds of mistakes								

Strengths and Special Interests

Please describe this student's principal strengths.

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

Does this student have some special interests or abilities that might be important for what he or she will do as an adult? ☐ **Yes** ☐ **No** ☐ **Possibly**

Please list these interests or abilities.

_____
_____
_____
_____
_____
_____

Please use the space below for any additional comments or observations that you think might be helpful to us in evaluating this student. Thank you.

_____
_____
_____
_____
_____
_____
_____

PREVIOUS COUNSELING

List any previous counseling your child has had.

Child's Age	Counselor or Psychologist Name and Location	How often and for what length of time was your child seen?	Why was your child counseled?
		_____ times per month for _____ months total.	
		_____ times per month for _____ months total.	
		_____ times per month for _____ months total.	
		_____ times per month for _____ months total.	
		_____ times per month for _____ months total.	
		_____ times per month for _____ months total.	

IF NOT ALREADY PROVIDED, ATTACH COPIES OF ANY REPORTS FROM COUNSELING.

*HEALTH BENEFITS INFORMATION

Do You have Health insurance?: ☐ Yes ☐ No

If you answered Yes, do you participate in a managed care plan? ☐ Yes ☐ No

Type of plan (HMO, PPO, etc.): _____

Name of plan: _____

Name and address of primary physician provider: _____

_____

Note: Please attach a copy of the front and back of you health insurance care (increase size at least 50% when copying). Please note that Pryor & Associates does not bill your insurance company directly but we will provide you with the necessary forms and documentation to file with your insurance company to receive reimbursement.

Does your plan cover psychological/psychiatric evaluations or treatment? ☐ Yes ☐ No

ADDITIONAL COMMENTS
(NOT ALREADY ADDRESSED)