

The Pisgah Institute for Psychotherapy and Education, P.A.
INFANT/ YOUNG CHILD PARENT QUESTIONNAIRE

Date _____

Child's Name _____ Age _____ DOB _____ Sex _____

Parent/s or Guardian/s

Mother _____ Age _____

Father _____ Age _____

Siblings _____ Age _____

_____ Age _____

_____ Age _____

Others living in home:

Name(s) _____ Relationship to child _____

What concerns do you have about your baby or young child?

Does your baby or young child have any health problems which concern you?

Who is your baby/young child's doctor?

Name of doctor _____

Address _____

Date of last visit to doctor _____

Reason for visit _____

BIRTH HISTORY

Was this a planned pregnancy? No Yes

Did you have any health or medical problems during the pregnancy, delivery, or in the postpartum period? If yes, please explain

During your pregnancy did you take any of the following? If yes, please describe

Prescription medications No Yes

Over the counter medications No Yes

Alcohol – beer, wine, hard liquor No Yes

Recreational drugs No Yes

Cigarettes/tobacco products No Yes

Where was your baby born?

Type of delivery: Vaginal C-section

Birth weight

Was your baby born prematurely? No Yes If yes, how many weeks early?

Did your baby have any problems during the pregnancy, delivery, or after the birth? No Yes
If yes, please explain:

Did you have any problems during the pregnancy, delivery, or after the birth? No Yes
If yes, please explain.

Did you experience depression or anxiety during the pregnancy or after the birth? No Yes

Did you get help for these problems? No Yes If yes, from whom?

MEDICAL HISTORY

Has your baby/young child had any illnesses or injuries? No Yes
If yes, please list the illness or injuries below and give your child's age.

Has your baby/young child ever been hospitalized? No Yes If yes, please explain

Has your baby/young child ever required surgery? No Yes If yes, please explain

Is your baby/young child taking any medications, vitamins, herbal treatments, or other remedies?
No Yes Please list:

Does your baby/young child have any allergies? No Yes If yes, please explain

DEVELOPMENTAL HISTORY

At what age did your young child first able to:

smile responsively	begin to crawl on arms and knees
roll all the way over	begin to walk independently
babble	say one word
sit up without support	put two words together

Have you have any of the following concerns about your child now or in the past?

Irritable, hard to soothe	No Yes
Resists cuddling	No Yes
Colic, frequent inconsolable crying	No Yes
Excessive restlessness	No Yes
Sleep problems	No Yes
Feeding problems	No Yes
Difficulty with transitions	No Yes
Very shy or standoffish	No Yes

Lack of eye contact No Yes
Frequent temper tantrums No Yes

Has your child had vision or hearing problem? No Yes If yes, please explain

Has your child ever had a developmental evaluation? No Yes If yes, please explain

Does your baby/young child receive any services such as early intervention; physical, occupational, or speech therapy; or visits from a nurse? No Yes If yes please explain

Was your baby or young child adopted? No ___ Yes___ If yes, at what age? _____

Is this a foster child? No ___ Yes___ If yes, at what age was child placed with you? _____

Have there been any major changes in your child's family in the last year such as moves, marriage or divorce, accidents, deaths, birth of a new sibling, illness, domestic violence or new job for a parent?
No Yes If yes, please explain

NUTRITION

How was your baby fed after birth? Breast Bottle

Did he/she have any feeding problems while in the hospital or later on? No Yes (explain)

How is your baby/young child being fed now? Breast Bottle Spoon fed Self feeds

How often is your baby/young child fed?

Are there any feeding problems such as choking, reflux, food refusals or preferences? No Yes
If yes, please explain

What foods is he/she being fed/eating now?

Are there any food allergies? No Yes If yes, please explain

ELIMINATION

Does your baby/young child have problems with:

Constipation	No Yes
Diarrhea	No Yes
Difficult urination	No Yes
Bedwetting	No Yes

At what age did you begin toilet training?

Is your child toilet trained? No Yes for urine bowel movements both

SLEEP

How many hours does your baby/child sleep in 24 hours?

Is your baby/young child having any sleep problems? No Yes (Please explain)

Where does your baby/young child sleep?

FAMILY MEDICAL HISTORY

Has anyone on either side of the immediate family (parents, siblings, grandparents, 1st cousins) had any of the following problems?

- Autism No Yes (who?)
- ADHD/ADD No Yes (who?)
- Learning problems No Yes (who?)
- Anxiety/Depression No Yes (who?)
- Bipolar Disorder No Yes (who?)
- Diabetes No Yes (who?)
- Vision Problems No Yes (who?)
- Hearing Problems No Yes (who?)
- Seizures/Epilepsy No Yes (who?)
- Heart attack No Yes (who?)
- Substance abuse No Yes (who?)

FAMILY SOCIAL HISTORY

Are you? married living together/unmarried single

How long have you been living in your current home?

Are you working?	Where?	Hours per week/shift
Mother _____	_____	_____
Father _____	_____	_____

What is the highest grade you have completed in school?

Mother _____

Father _____

What social supports do you have who help with childcare, finances, etc.?

Is there anything else you feel I should know about your child or your family?

Person(s) completing this form _____

Relation to child being seen _____ Date _____

Thank you so much for completing this questionnaire. It will help me better understand your child and your family and allow me to focus on the concerns you have during your visit.