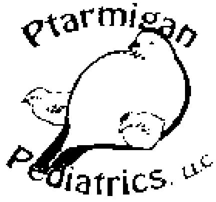


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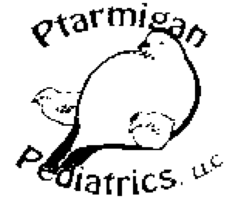


Dear Parents,

In order to perform a thorough evaluation of your child's learning capabilities and behavior, there is some important information that we need to obtain from you and your child's teacher(s). The checklist below outlines what information is needed to begin the process.

**Package:**

- Your child's medical records (If you need us to request records from a previous provider you may fill out a records request at our front desk)
- Teacher/School questionnaire (available at our front desk)
- Parent questionnaire – Please be as complete and provide as much detail and description as possible (available at our front desk)
- Hearing and Vision screening (if available) – These screening tests are routinely done by the school nurse(s) in the public school system for children in grades K, 1, 3 and 5. Parents can also request screening tests at anytime for a child in a grade other than those mentioned. For preschoolers or those not in the public school system, please check with the clinic staff for information on how to arrange the screening tests.
- Current Individualized Education Plan (IEP), if any
- Any past testing performed by mental health providers, school psychologists or resource teachers

After you've gathered all the information, bring the package to our office and a physician will review it. Once the package has been reviewed, our office nurse will contact you to schedule an initial appointment. Plan on the initial appointment lasting at least 45 minutes.

We hope this letter explains what you need for the initial appointment. Please feel free to call our office at 907-357-4543 from 9 a.m. to 5 p.m. Monday to Thursday and 9 a.m. to 3 p.m. Friday, if you have any questions. We look forward to meeting with you and your child.

Sincerely,

Laura Peterson, M.D.
Dr. Bruce W. Hess, D.O.

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Date: ___________

**Parent Questionnaire – Part I**

Child's Name: ________________________________ Birth date: ____________________

Nickname: ________________________________

Parent(s) name: ______________________________ Home phone: _________________

Work phone: ________________________________

Address: ______________________________________________________________

## Description of Problem/Concerns

Please describe your reasons for wanting an evaluation of your child's learning and/or behavior problems. Be as specific as possible in your description of the problem (If you need more room, please attach a separate sheet to this form.)

_______________________________________________________________________________
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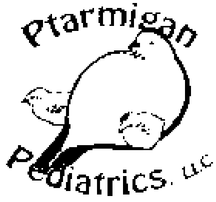


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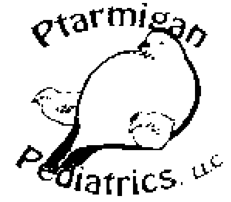


**Description of Problem (continued)**

When did you start noticing these problems? ____________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What do you think maybe causing these problems? ______________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What have you tried to do in the past to deal with these problems? _________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Has a psychiatrist, psychologist, doctor, social worker or other health care/educational professional ever seen this child for these problems? Yes / No (If yes, please state when, why and by whom they were seen) ______________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Has anyone else in the family been seen for similar problems as those that this child is having?
Yes / No (If yes, please state when, why and who saw them) _______________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

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**Description of Problem (continued)**

Has your child previously been evaluated or tested for intellectual, learning, developmental or psychological problems? Yes / No (If yes, please state when, why and by whom they were seen and bring in a copy of the evaluation if possible)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Medical History**

Were there any problems or complications while you were pregnant with this child? Yes / No (If yes, please explain) ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Was this child born prematurely, at full term or was he/she overdue? (please circle one)

What was the child's birth weight? ___________________________

Please list any illness/injuries/conditions this child has had: ______________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Has the child ever been hospitalized? Yes / No (If yes, please list dates of and reasons for hospitalization) ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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## Medical History (continued)

Does your child take any medications now? Yes / No (If yes, please list name(s) of medication(s) and the amount he/she takes per day) ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Has the child ever taken medicine to control his/her behavior? Yes / No (If yes, please state when medication was taken, the name of the medication, amount per day and what effects it had on the behavior) ______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Development

Please give the age when your child:

Sat alone _______________ Stood alone _______________ Walked alone __________

Toilet trained during the day ________________ Toilet trained at night _______________

Talked well ________________ Tied shoestring alone _______________

Did he/she develop as quickly as his/her brothers and sisters? Yes / No / NA

## Family

Please list all the adults who live in the same household as the child:

| Name | Age | Relation to Child | Occupation | Education |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Is/Are the parent(s) listed above the biological parent(s)? Yes / No

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**Family (continued)**

Is the child adopted? Yes / No If yes, does the child know? Yes / No

Was either parent separated, divorced or widowed? Yes / No

List full names of all children either living in or out of the household:

| Name | Age | Occupation/School grade | Living at home |
|---|---|---|---|
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |
| | | | Yes / No |

Please circle answer:

| | |
|---|---|
| Are there any serious problems in the family? | Yes / No |
| Are there marital problems? | Yes / No |
| Are there financial problems? | Yes / No |
| Is either parent having emotional problems? | Yes / No |
| Are there arguments about how to raise this child? | Yes / No |

Do any of the child's blood relatives have a history of: (if yes, who)

| | | |
|---|---|---|
| Epilepsy or convulsions | Yes / No | ______________________ |
| Reading problems | Yes / No | ______________________ |
| Attention Deficit Disorder | Yes / No | ______________________ |
| Diabetes | Yes / No | ______________________ |
| Nervous system disease | Yes / No | ______________________ |
| Mental illness | Yes / No | ______________________ |
| Other chronic illness | Yes / No | ______________________ |

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## Schools

Were any grades skipped? Yes / No Which one(s)? ____________________

Were any grades repeated? Yes / No Which one(s)? ____________________

Is the child in any special classes? Yes / No (If yes, explain) ______________________________

________________________________________________________________________________

________________________________________________________________________________

| | |
|---|---|
| Did this child attend nursery school or kindergarten? | Yes / No |
| Does this child have difficulties with schoolwork? | Yes / No |
| Does this child trouble getting ready for or getting to school? | Yes / No |
| Has this child ever been suspended from school? | Yes / No |
| Have you had a conference with this child's teacher in the past month? | Yes / No |

How many schools has this child attended? ____________________

How many school days has this child missed so far this year? ____________________

Approximately how many school days were missed last year? ____________________

## Friends

| | |
|---|---|
| Gets along with children the same age? | Yes / No |
| Trouble keeping friends? | Yes / No |
| Fights a lot with children or defiant with adults? | Yes / No |
| Prefers to play alone? | Yes / No |
| Close friend(s)? | Yes / No |

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## Mood

| | |
|---|---|
| Is your child often tense? | Yes / No |
| Does your child worry a lot? | Yes / No |
| Is your child unhappy often? | Yes / No |
| Is your child angry often? | Yes / No |
| Readily talks when bothered by something? | Yes / No |
| Talks to him/herself? | Yes / No |
| Has mood similar to a parent? | Yes / No |

## Discipline

| | |
|---|---|
| Is your child difficult to discipline? | Yes / No |
| Does your child break rules often? | Yes / No |
| Does your child quarrel a lot with brothers and sisters? | Yes / No / NA |
| Does your child have a sense of what is right and wrong? | Yes / No |

What method of discipline do you use? ______________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Who does the disciplining? ______________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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**Other Information**

Please circle the items below which describe your child:

| | | |
|---|---|---|
| Muscle/joints ache | Clumsy | Hard to waken |
| Headaches | Dizzy/fainting spells | Lazy |
| Cries excessively | Nervous/high strung | Bites nails |
| Frequent daydreaming | Thumb sucking | Restless/overactive |
| Gets teased | Temper tantrums | Appears tired |
| Restless sleeper | Recently gained/lost weight | Nightmares |
| Suicide attempt | Physical complaints | Trouble getting to sleep |
| Concentration problem | Daytime wetting | Sexual problems |
| Soiling underwear | Bedwetting | Running away |
| Constipation | Highly conscientious | Indigestion/nausea |

What three characteristics do you like best about your child?

1. ______________________________________________

______________________________________________

2. ______________________________________________

______________________________________________

3. ______________________________________________

______________________________________________

What three characteristics concern you the most?

1. ______________________________________________

______________________________________________

2. ______________________________________________

______________________________________________

3. ______________________________________________

______________________________________________

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