

# EVERED PARENT QUESTIONNAIRE (EPQ)

**LAEEQ EVERED, PSY.D.**

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Child's Name: \_\_\_\_\_ Home Address: \_\_\_\_\_  
 Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender: M / F (street) \_\_\_\_\_  
 Ethnic Background: \_\_\_\_\_ (city) \_\_\_\_\_ (State/ZIP) \_\_\_\_\_  
 Language(s) Spoken: \_\_\_\_\_ Home Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Grade: \_\_\_ School: \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_ Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

Individuals residing with child:	Name (First & Last)	Age	Occupation	Education (Years/degree)
(Please check) Bio./Step/Adoptive/Foster				
Mother ( ) ( ) ( ) ( )	_____	_____	_____	_____
Father ( ) ( ) ( ) ( )	_____	_____	_____	_____
(Please check) Full / Half / Step / Foster				
Brothers & ( ) ( ) ( ) ( )	_____	_____	_____	_____
Sisters ( ) ( ) ( ) ( )	_____	_____	_____	_____
( ) ( ) ( ) ( )	_____	_____	_____	_____
( ) ( ) ( ) ( )	_____	_____	_____	_____
( ) ( ) ( ) ( )	_____	_____	_____	_____
( ) ( ) ( ) ( )	_____	_____	_____	_____
( ) ( ) ( ) ( )	_____	_____	_____	_____
( ) ( ) ( ) ( )	_____	_____	_____	_____

(Relationship to child)

Others in the household \_\_\_\_\_  
 (Grandparent/Aunt/ \_\_\_\_\_  
 Uncle/Cousin/Other) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Referred by: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ City \_\_\_\_\_  
 State/Zip \_\_\_\_\_  
 Pediatrician: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ City \_\_\_\_\_  
 State/Zip \_\_\_\_\_  
 Therapist: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ City \_\_\_\_\_  
 State/Zip \_\_\_\_\_

Purpose for Consultation/Evaluation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prior Residences**

Age beginning - ending	City	State or Country	If not parents, with whom?
1. <u>0</u> - _____	_____	_____	_____
2. _____ - _____	_____	_____	_____
3. _____ - _____	_____	_____	_____
4. _____ - _____	_____	_____	_____
5. _____ - _____	_____	_____	_____
6. _____ - _____	_____	_____	_____
7. _____ - _____	_____	_____	_____
8. _____ - _____	_____	_____	_____

**Education**

Education	Grade Level	Name of School	City/State	Grade Average (A,B,C,D,F or GPA)
Kindergarten	K	_____	_____	_____
Elementary (1 <sup>st</sup> -6 <sup>th</sup> )	1 <sup>st</sup> - _____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Junior High (7 <sup>th</sup> -8 <sup>th</sup> /9 <sup>th</sup> )	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
High School(9 <sup>th</sup> /10 <sup>th</sup> -12 <sup>th</sup> )	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Current Teacher: \_\_\_\_\_

Subjects child gets best grades: \_\_\_\_\_

Subjects child gets lowest grades: \_\_\_\_\_

Subjects for which child receives tutoring: \_\_\_\_\_

Academic Awards: \_\_\_\_\_

Standardized Test Scores (SAT, STAR): \_\_\_\_\_

School Sports/Activities/Clubs: \_\_\_\_\_

Has your child ever: *(Please circle Yes or No)*

- Y / N Skipped any grades? If yes, which? \_\_\_\_\_
- Y / N Repeated or failed any grades? If yes, which? \_\_\_\_\_
- Y / N Identified as Gifted or Talented? At what age? \_\_\_\_\_
- Y / N Placed in Special Education Classes? Subject(s) & age? \_\_\_\_\_
- Y / N Had a modified learning program/individual education plan (IEP)? Age? \_\_\_\_\_
- Y / N Identified as having a Learning Disability? Type? \_\_\_\_\_
- Y / N Identified as Dyslexic? \_\_\_\_\_
- Y / N Identified as Hyperactive or having Attention difficulties? \_\_\_\_\_
- Y / N Been Suspended? If yes, number of times \_\_\_\_\_ Reason(s) \_\_\_\_\_
- Y / N Been Expelled? If yes, number of times \_\_\_\_\_ Reason(s) \_\_\_\_\_

Has your child ever been arrested or involved in the legal system/juvenile hall? Y / N

If yes: Age	Reason/Incident	Resulting Action (Arrest, detention)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Interests and Activities**

Sports or Recreations:  
(Including music & video games, etc)

Organizations:  
(Scouts, 4H, etc)

Hobbies/collections/interests:  
(Model building, coins, dinosaurs)

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<hr/>	<hr/>	<hr/>

Favorite music: \_\_\_\_\_ Favorite TV show/movie: \_\_\_\_\_

What are your child's assets & strengths? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Developmental History** (if child was adopted, please fill in as much information as you are aware of)

During pregnancy, did the mother:

Y / N Receive regular prenatal care?

Y / N Take Medication? Name/Type/Duration: \_\_\_\_\_

Y / N Smoke? Amount/Duration: \_\_\_\_\_

Y / N Drink alcoholic beverages? Amount/Type/Duration: \_\_\_\_\_

Y / N Use Drugs? Amount/Type/Duration: \_\_\_\_\_

Please list any complications during the pregnancy: (excessive vomiting, blood loss, infections, toxemia, etc.)

\_\_\_\_\_  
 \_\_\_\_\_

Duration of pregnancy (weeks): \_\_\_\_\_ Duration of labor: \_\_\_\_\_ Apgars: \_\_\_\_/\_\_\_\_ Birth Weight: \_\_\_\_\_

Check all that apply:  Labor induced  Forceps  Caesarean  Breech  
 Jaundice  Incubator  Breathing problems

Presence of birth defects, feeding problems, sleeping problems, growth delays, or other complications?

\_\_\_\_\_  
 \_\_\_\_\_

Were any of the following present (to a significant degree) during infancy or the first few years?

- Unusually quiet  Colic  Difficult to soothe  Did not like to be held or cuddled  
 Head banging  Not alert  Excessive sleep  Constantly into everything  
 Restlessness  Diminished sleep  Excessive number of accidents compared to other children

Please indicate the approximate age at which your child showed the following behaviors:

	Age	Early	Average	Late	Never		Age	Early	Average	Late	Never
Smiled	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tied shoelaces	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolled over	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressed self	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sat alone	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fed self	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawled	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trained					
Walked	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Day	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ran	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babbled	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel trained	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First word	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rode tricycle	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sentences	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rode bicycle	____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Vision Problems  No  Yes (Describe): \_\_\_\_\_

Hearing Problems  No  Yes (Describe): \_\_\_\_\_

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Illness or Condition	Age(s)		Age(s)	Describe:
<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Loss of consciousness	_____	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Concussion(s)	_____	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Injury to head	_____	_____
<input type="checkbox"/> Whooping Cough	_____	<input type="checkbox"/> Broken bones	_____	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Auto/bicycle accidents	_____	_____
<input type="checkbox"/> Scarlet fever	_____	<input type="checkbox"/> Surgery(s)	_____	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Hospitalizations	_____	_____
<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Poisoning	_____	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Severe headaches	_____	_____
<input type="checkbox"/> High fever	_____	<input type="checkbox"/> Bone or joint disease	_____	_____
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Ear infections	_____	<input type="checkbox"/> Paralysis	_____	_____
<input type="checkbox"/> Hay fever	_____	<input type="checkbox"/> High blood pressure	_____	_____
<input type="checkbox"/> Rheumatic fever	_____	<input type="checkbox"/> Heart disease	_____	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Anoxia/Hypoxia	_____	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> STD	_____	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Cancer	_____	_____
<input type="checkbox"/> Jaundice/hepatitis	_____	<input type="checkbox"/> Physical abuse	_____	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Sexual abuse	_____	_____
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Other: _____	_____	_____

**Family Medical History** (Place a check next to condition of family member: parent, brother, sister, grandparent, aunt, etc.)

<u>Condition</u>	<u>Relationship</u>	<u>Condition</u>	<u>Relationship</u>	<u>Condition</u>	<u>Relationship</u>
<input type="checkbox"/> Seizures or Epilepsy	_____	<input type="checkbox"/> Tics or Tourette's Syndrome	_____	<input type="checkbox"/> Alcohol Abuse	_____
<input type="checkbox"/> Attention Deficit	_____	<input type="checkbox"/> Neurological Disorder	_____	<input type="checkbox"/> Drug Abuse	_____
<input type="checkbox"/> Hyperactivity	_____	<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Suicide Attempt	_____
<input type="checkbox"/> Learning Disabilities	_____	<input type="checkbox"/> Anxiety Disorder	_____	<input type="checkbox"/> Physical Abuse	_____
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Mental Illness: _____			

**Previous evaluations or treatments:**

	Date/Duration	Type of Evaluation/Treatment	Examiner/Clinician/Institution
Psychotherapy	_____	_____	_____
Psychiatric	_____	_____	_____
Psychological Testing	_____	_____	_____
Neuropsychological	_____	_____	_____
Educational/Academic	_____	_____	_____
Speech Pathology	_____	_____	_____
Occupational Therapy	_____	_____	_____

**Current Medications:**

<i>Medication</i>	<i>Reason taken</i>	<i>Dosage</i>	<i>Start date</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Past Medications:**

<i>Medication</i>	<i>Reason taken</i>	<i>Dosage</i>	<i>Start &amp; end dates</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Cognitive Skills**

(Please rate your child's cognitive skills relative to other children of the same age)

	Above Average	Average	Below Average	Severe Problem
Speech	( )	( )	( )	( )
Comprehension of speech	- - - ( )	- - - ( )	- - - ( )	- - - ( )
Problem solving	( )	( )	( )	( )
Attention span	- - - ( )	- - - ( )	- - - ( )	- - - ( )
Organizational Skills	( )	( )	( )	( )
Remembering events	- - - ( )	- - - ( )	- - - ( )	- - - ( )
Remembering facts	( )	( )	( )	( )
Learning from experience	- - - ( )	- - - ( )	- - - ( )	- - - ( )
Understanding concepts	( )	( )	( )	( )

(Check any specific problems)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Poor articulation          | <input type="checkbox"/> Forgets to do things    | <input type="checkbox"/> Difficulty finding words to express self |
| <input type="checkbox"/> Poor grammar               | <input type="checkbox"/> Frequently loses things | <input type="checkbox"/> Difficulty planning tasks                |
| <input type="checkbox"/> Disorganized speech        | <input type="checkbox"/> Easily distracted       | <input type="checkbox"/> Frequently forgets instructions          |
| <input type="checkbox"/> Poor handwriting           | <input type="checkbox"/> Slow learner            | <input type="checkbox"/> Doesn't foresee consequences of actions  |
| <input type="checkbox"/> Poor understanding of time | <input type="checkbox"/> Slow thinking           | <input type="checkbox"/> Difficulty with math/handling money      |

**Behavioral Checklist** (Place a check mark next to behaviors you believe your child exhibits to an excessive degree)

**Sleeping and Eating**

- Nightmares    Trouble sleeping    Under Eats    Eats excessively    Binges    Purges

**Social Development**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Prefers to be alone       | <input type="checkbox"/> Teased by other children | <input type="checkbox"/> More interested in objects than people           |
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Talks during class       | <input type="checkbox"/> Doesn't empathize with others                    |
| <input type="checkbox"/> Excessively shy           | <input type="checkbox"/> Disruptive at school     | <input type="checkbox"/> Not sought out for friendship by peers           |
| <input type="checkbox"/> Poor eye contact          | <input type="checkbox"/> Rebellious               | <input type="checkbox"/> Difficulty seeing another person's point of view |
| <input type="checkbox"/> Overly trusting of other  | <input type="checkbox"/> Bullies other children   | <input type="checkbox"/> Doesn't appreciate humor                         |

**Motor Skills/Sensory**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Poor fine motor coordination  | <input type="checkbox"/> Bladder control problems        | <input type="checkbox"/> Overreacts to touch        |
| <input type="checkbox"/> Poor gross motor coordination | <input type="checkbox"/> Poor bowel control (soils self) | <input type="checkbox"/> Overreacts to noise        |
| <input type="checkbox"/> Problems with taste or smell  | <input type="checkbox"/> Motor/vocal tics                | <input type="checkbox"/> Hand flapping when excited |

**Behavior**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Low self-esteem                          | <input type="checkbox"/> Irritable, angry, resentful | <input type="checkbox"/> Lying         | <input type="checkbox"/> Requires a lot of supervision         |
| <input type="checkbox"/> Seems depressed                          | <input type="checkbox"/> Throws or destroys things   | <input type="checkbox"/> Skips school  | <input type="checkbox"/> Not affected by negative consequences |
| <input type="checkbox"/> Cries frequently                         | <input type="checkbox"/> Low frustration tolerance   | <input type="checkbox"/> Stealing      | <input type="checkbox"/> Excessively worried/anxious           |
| <input type="checkbox"/> Frequent tantrums                        | <input type="checkbox"/> Cruelty to animals          | <input type="checkbox"/> Runs away     | <input type="checkbox"/> Overly preoccupied with details       |
| <input type="checkbox"/> Argues with adults                       | <input type="checkbox"/> Daredevil behavior          | <input type="checkbox"/> Stubborn      | <input type="checkbox"/> Overly attached to certain objects    |
| <input type="checkbox"/> Strikes out at others                    | <input type="checkbox"/> Frequently fidgety          | <input type="checkbox"/> Hypervigilant | <input type="checkbox"/> Excessive daydreaming                 |
| <input type="checkbox"/> Impulsive (does things without thinking) | <input type="checkbox"/> Drug abuse                  | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Sexually active                       |
- Dangerous to self or others: \_\_\_\_\_
- Purposely harms or injures self: \_\_\_\_\_
- Talks about killing self: \_\_\_\_\_
- Unusual fears, habits or mannerisms: \_\_\_\_\_
- Other problems: \_\_\_\_\_

How is your child disciplined? \_\_\_\_\_

Current/Prior Diagnoses:(include dates) \_\_\_\_\_

Is there any other information that you believe may help in assessing/treating your child? \_\_\_\_\_

Name of individual(s) who completed this form: \_\_\_\_\_