Confidential Parent Questionnaire

Although some of the questions asked may be difficult to answer, your responses will help us identify areas of concern and aide in our assessment process. The more information you share, the better we will be able to help your child and your family by providing the best possible treatment. Thank you for your time and candor.

Name of child/adolescent: ________________________________Today's date: ________________

DOB: _______________________ Age: ___________ Gender: M / F __________________

Ethnicity: __________________________________ Religion:______________________________

Person completing this form: ___________________________ Relationship:___________________

Name(s) of Parent/Guardian: ____

Address: ____

Home Phone: __________________________Cell Phone: ___________________________________

Referral Source: ____

Please describe what led you here today:

____
____
____
____

Please describe how you wish to be helped (counseling for child, family therapy, parent support, need for diagnosis, referral, other):

____
____
____

Your Child's Overall Functioning:

Please describe strengths and/or concerns related to your child in the following areas.

School functioning (attendance, performance, relationships with peers/teachers):

____
____
____

If your child has a 504 or IEP, please indicate and describe below:

____

Peer Relationships (presence of friends, level of social activity, extra-curricular activities):

____
____
____

Family/Community:

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____

____

Please describe any legal/criminal problems:

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____

____

Your Child's Therapeutic History:

Please describe any suspicion or known substance abuse (including type(s) of substances, frequency, where & when used, and severity such as black outs, seizures):

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____

____

Past mental health treatment, including any previous counseling (in-home or outpatient), previous medications prescribed, and prior psychiatric hospitalizations:

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____

____

____

Your Child's Medical History:

(Major illnesses, hospitalizations, include current medical treatment):

____

____

Date of last physical exam: __________________________

Name & Address of Pediatrician:____

Your

Current Medications (list all)	**Dosage**	**Person Prescribing Medication**

Child's Developmental History:

Pregnancy Planned: Yes / No

Pregnancy complications: Yes / No (if yes, please describe):

____

____

Birth complications or problems: Yes / No (if yes, please describe):

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____

____

Please describe any problems with sleep patterns, eating or personality during infancy:

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____

Milestones: Please specify *on time*, *early*, *late* and age when milestone was reached.

Walking ____________________ Talking ____________________ Toileting ____________________

Was Birth to Three or any other agency/specialist involved in your child's care? If so, please describe services provided:

____

____

Please list any problems or concerns related to your child's early development (birth to school age):

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____

____

____

Please list any problems or concerns related to your child's development since entering school:

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____

<u>Your Family Composition</u>:
If child has two "households", please record both with a blank line in between and note address of second household

Name	Age	Relation to Child (birth parent, step, adoptive, sibling)	Occupation

Please list other residences where your child has lived:

____

____

<u>Your Family History:</u>
How would you describe your family? How would you describe relationships between family members?

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____

____

____
____

For the remaining ***Family History*** *questions, please include child's immediate family AND that of birth/step parents (two generations)*

History of family medical problems (please describe):
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____
____

History of family psychiatric problems (please describe):
____
____
____

History of suicidal thoughts/plans/gestures by any family member (please describe):
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____
____

History of family substance use or abuse (please describe):
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____
____

Family history of abuse (verbal, physical, emotional, sexual, neglect – please describe):
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____
____
____
____

Is anyone in the family currently participating in their own therapy? Yes / No (if yes, please describe)
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____

Have you ever felt emotionally unsafe at home? Please describe:
____
____

Has anyone in your family ever felt emotionally unsafe at home? Please describe:
____
____

Are there any weapons in your home?_________ If so, please describe ___________________________________
____

History of significant events such as losses, transitions, trauma, deaths (please describe):
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____
____
____

Child Checklist of Characteristics:

Please review this checklist. It contains concerns as well as positive traits that apply mostly to children. Mark any items that describe your child. Feel free to add any others in the space provided below.

❑ Affectionate
❑ Argues, "talks back,"
❑ Bullies/intimidates, teases,
❑ Bossy to others, picks on, provokes
❑ Cheats
❑ Cruel to animals
❑ Concern for others
❑ Conflicts with parents over multiple issues
❑ Complains
❑ Cries easily, feelings are easily hurt
❑ Dawdles, procrastinates, wastes time
❑ Difficulties with parent's paramour/new marriage/new family
❑ Dependent, immature
❑ Developmental delays
❑ Disrupts family activities
❑ Disobedient, uncooperative, refuses, doesn't follow rules
❑ Distractible, inattentive, poor concentration, daydreams, slow to respond
❑ Dropping out of school
❑ Drug or alcohol use
❑ Eating—appetite increase or decrease
❑ Overeats ❑ Under eats
❑ Exercise problems
❑ Extracurricular activities interfere with academics
❑ Poor/Failing grades in school
❑ Fearful
❑ Fighting, hitting, aggressive, hostile, threatens, destructive
❑ Fire setting
❑ Friendly, outgoing, social
❑ Hypochondriac, always complains of feeling sick
❑ Immature, "clowns around," has only younger playmates
❑ Imaginary playmates, fantasy
❑ Independent

❑ Interrupts, talks out, yells
❑ Lacks organization, unprepared
❑ Lacks respect for authority, provokes, manipulates
❑ Learning disability
❑ Legal difficulties—loitering, vandalism, stealing, drug sales
❑ Likes to be alone, withdraws, isolates
❑ Lying
❑ Low frustration tolerance, irritability
❑ Moody
❑ Mute, refuses to speak
❑ Nail biting
❑ Nervous
❑ Nightmares
❑ Need for high degree of supervision
❑ Obedient
❑ Obesity
❑ Overactive, restless, hyperactive, fidgety
❑ Oppositional, resists, refuses, negativism
❑ Prejudiced, bigoted, insulting, name calling, intolerant
❑ Pouts
❑ Recent move, new school, loss of friends
❑ Relationships with siblings/peers are poor
❑ Responsible
❑ Rocking or other repetitive movements
❑ Runs away
❑ Sad, unhappy
❑ Self-harming behaviors—biting or hitting self, head banging
❑ Self-harming behaviors—cutting or scratching self
❑ Speech difficulties
❑ Sexual—inappropriate sexual behaviors/preoccupations
❑ Shy, timid
❑ Stubborn
❑ Suicide talk or attempt
❑ Swearing, foul language
❑ Temper tantrums, rages
❑ Thumb sucking, finger sucking, hair chewing
❑ Tics—involuntary rapid movements, noises, or word productions
❑ Teased, picked on, victimized, bullied
❑ Truant, school avoiding
❑ Under active, slow-moving
❑ Uncoordinated, accident-prone
❑ Wetting or soiling the bed or clothes
❑ Works too much
❑ Can't keep a job

Any other characteristics:
____
____

Please share anything else you think might be important:
____
____
____