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CHILD/ADOLESCENT – PARENT QUESTIONNAIRE

Date:__________ **Form completed by:**________________________ **Relationship to child:**__________

Referred by (name, telephone):____________________________________

Name of Child:____________________ Gender: M ☐ F☐ Primary Language:____________

Date of Birth:__________ Age:_____ Place of Birth:______________ Ethnic Origin:____________

Home Address:____

Home Phone:________________ Work Phone:______________ Cell Phone:______________

Childs Primary Care Physician (name, address and phone number):________________________

____

Medical History

Has your child ever had any of the following problems?	Yes	No	When
Seizures or convulsions			
Loss of consciousness or head injury			
Rashes or skin problems			
Meningitis			
Food allergies			
Drug or medication allergies			
Pneumonia			
Anemia or low blood count			
Heart problems			
Kidney or urinary problems			
Bowel problems			
Trouble with visions			
Trouble with hearing			
Lack of weight gain			
Poisoning or medication overdose			
Serious injury			
Hospitalization			
Surgery			
Diabetes			

Please list any other important or physical problems:________________________

____

____

Please list any medications that our child has used over a long period of time:______________

____

In general, has your child's health been any of the following:

☐ Excellent (rarely sick or injured, when sick recovers very quickly)
☐ Good (is not often sick or injured, illnesses are fairly short lived)
☐ Fair (frequently sick or injured, illness often linger or recur)
☐ Poor (chronically sick or injured)

Presenting Issues

Please explain why you have chosen to seek counseling for your child at this time:____________________________

____

____

____

Do any of the following apply to your child?

☐ Unhappy	☐ Irritable	☐ inflexible	☐ head banging	☐ sexual confusion
☐ drug use	☐ angry outbursts	☐ withdrawn	☐ disrespectful	☐ rocking
☐ sexual promiscuity	☐ alcohol use	☐ daydreaming	☐ fearful/phobic	☐ skips school
☐ runs away	☐ school performance	☐ suicidal thoughts	☐ awkward/clumsy	☐ overactive
☐ unkind to others	☐ atypical behavior	☐ bed wetting	☐ suicidal gestures	☐ slow/sluggish
☐ destructive	☐ poor concentration	☐ atypical thoughts	☐ soiling pants	☐ lying
☐ distractible	☐unmotivated	☐ legal problems	☐ fire setting	☐ eating problems
☐ unreliable	☐ running away	☐ peer conflict	☐ stealing	☐ sleep problems
☐ anxious	☐ impulsive	☐ self-harm	☐ often tired sick	

List any others:____

How long have these issues existed (# of weeks, months, years):________________________________

Is there anything that you think may have led up to your child's current difficulties?_____________________

____

____

Has your child received counseling or mental health services before? If so, please list the name, facility and telephone number of the provider(s), dates of treatment and results:

Name	**Facility**	**Phone**	**Dates of Treatment**	**Result of Treatment**

DEVELOPMENTAL HISTORY

Planned pregnancy ☐ Yes ☐ No Comments:____

Typical pregnancy ☐ Yes ☐ No If mother was ill or distressed during pregnancy, please explain:_____________

____

Did the mother abuse alcohol/drugs during pregnancy? ☐ Yes ☐ No Describe:_____________________________

Length of active labor:_______ Describe Labor: ☐ Difficult ☐ Manageable/easy Comments:______________________

____

DEVELOPMENTAL HISTORY (continued)

Full Term: ☐ Yes ☐ No If premature, how early________ If overdue, how late __________

Type of delivery: ☐ Vaginal ☐ Cesarean ☐ With instruments ☐ Head first ☐ Breech

Birth weight:_______lbs. _____oz. Birth length:__________

Did infant require oxygen: ☐ Yes ☐ No If so, how long?____

Did the infant require blood transfusions? ☐ Yes ☐ No X-ray ☐ Yes ☐ No Explain:__________________

Newborn Period

	Yes	No	Explain
Breast-fed (when was child weaned			
Formula-fed			
Irritability			
Vomiting			
Difficulty breathing			
Difficulty sleeping			
Convulsions/Twitching			
Colic			
Average weight gain			

Milestones

	Age
Smiled	
Sat up without support	
Crawled	
Walked	
Spoke single words	
Spoke sentences	
Bladder trained	
Bowel trained	

During First Three Years of Life

	Yes	No	Sometimes	Explain
Illness				
Change in caretakers				
Primarily attached to one caretaker				
Enjoyed being held				
Alert to environment				
Explored environment				
Interacted with children				
Interacted with adults				
Predictable sleeping and waking patterns				
Predictable bladder and bowel movements				
Predictable hunger				

School Adjustment/Functioning

How old was your child when he/she started daycare/preschool/other program?______________________________

Describe your child's experience:____

School History

Name of School	Start Date	Grades Completed	Types of Classes	Child's Experience

Has your child every skipped a grade? ☐ Yes ☐ No Repeated a grade? ☐ Yes ☐ No Explain:__________________

Has your child ever had any specific learning difficulties? ☐ Yes ☐ No Explain:______________________________

Has your child ever had a tutor? ☐ Yes ☐ No Does your child work with a tutor now? ☐ Yes ☐ No

Is your child receiving special education services? ☐ Yes ☐ No If yes, please describe:________________________

Is your child currently have an IEP? ☐ Yes ☐ No If yes, please explain:_____________________________________

Has your child ever had testing at school? ☐ Yes ☐ No If yes, why/when did this occur, who conducted the testing, and what were the general results?____

School Performance

Highest grade on last report card:___ What subject:______________ Lowest grade:_____ What subject:_______________

Favorite subject:____________ Least favorite subject:_________________

Does your child appear motivated for school? ☐ Yes ☐ No

School Performance (continued)

Has your child ever been suspended or expelled? ☐ Yes ☐ No If yes, please explain:____________________

Has your child ever had difficulty with the police ☐ Yes ☐ No If yes, please explain:____________________

Has your child ever appeared in juvenile court? ☐ Yes ☐ No If yes, please explain:____________________

Has your child ever been employed? ☐ Yes ☐ No List job, employer, and duration:____________________

Has your child ever had any frightening or traumatic experiences? ☐ Yes ☐ No if yes, please explain:__________

Has your child ever experienced any physical or sexual abuse? If so, please explain:____________________

What are your child's strengths?____________________

Does your child have a best friend? ☐ Yes ☐ No If yes, do you think it is a healthy relationship? ☐ Yes ☐ No
If no, please explain:____________________

List your child's special interests, hobbies, skills:____________________

Do you feel uncomfortable about any of your child's hobbies or interest? ☐ Yes ☐ No If yes, please explain:__________

Does your child have any pets? ☐ Yes ☐ No If yes, describe type of animal, length of ownership, relationship:__________

Current Family Situation

Parent #1 Name:____ Gender: ☐ M ☐ F
Relationship to child: ☐ Birth parent ☐ Adoptive parent ☐ Relative ☐ Other (explain):__________

Birth place:____________________ Date of Birth:________ Age:____ Primary language:__________

Occupation:__________ Place of employment:____________________ Education:__________

Ethnic origin:__________ Religious background:____________________ Current spiritual practice:__________

Any children from previous marriages/relationships not living with you? ☐ Yes ☐ No If yes, please explain:__________

____

Please describe any personal or family problems from your childhood:______________________

____

Please describe any current issues:______________________________

____

Are you currently receiving treatment of these issues? ☐ Yes ☐ No

Parent #2 Name:____ Gender: ☐ M ☐ F
Relationship to child: ☐ Birth parent ☐ Adoptive parent ☐ Relative ☐ Other (explain):__________

Birth place:____________________ Date of Birth:________ Age:____ Primary language:__________

Occupation:__________ Place of employment:____________________ Education:__________

Ethnic origin:__________ Religious background:____________________ Current spiritual practice:__________

Any children from previous marriages/relationships not living with you? ☐ Yes ☐ No If yes, please explain:__________

____

Please describe any personal or family problems from your childhood:______________________

____

Please describe any current issues:______________________________

____

Are you currently receiving treatment of these issues? ☐ Yes ☐ No

Status of Relationship: ☐ Married ☐ Long term commitment ☐ Separated ☐ Divorced ☐ Widowed
If one parent is deceased: Name:___ Year of Death:_______ Cause of Death:__________________

Would you describe your relationship as having: ☐ No difficulties ☐ Occasional difficulties ☐ frequent difficulties

What are the strengths of this relationship?______________________________

____

How would each parent describe the difficulties in the relationship?______________________

____

____

Current Family Situation (continued):

How are current difficulties being addressed?____

Have you received counseling for relationship issues? ☐ Yes ☐ No If yes, please describe (include provider name and dates):____

____

Has the child ever been separated from either parent? (if adoption, foster care, or guardianship applies, see below):

Parent Name	**Dates of Separation**	**Age of child**

Describe nature of separation and child's response:____

____

____

Was either parent unable or unwilling to care for the child at any time? ☐ Yes ☐ No Which parent?__________

If yes, please describe nature of difficulties and child's understanding of the situation/response:__________

____

____

Adoption, Foster Care, or Guardianship

Please check: ☐ Adoption ☐ Foster care ☐ Guardianship ☐ Other (describe):__________________

Name and address of agency/organization involved:____

____

Child's State, Country of birth:____

Child's age at time of adoption/foster care/guardianship:_____Date of legal adoption:________Pending adoption?_______

If pending, what is the status?:____

Describe the adoption/foster care/guardianship process. Where there any complications?:____

____

____

Is this an **open or closed** adoption/foster care/guardianship: ☐ Open ☐ Closed

If open, what is the nature of the relationship that you and your child has with the birth parents? How often does your child talk and/or visit with the birth parents?:____

____

Adoption, Foster Care, or Guardianship (continued)

If closed, describe your child's understanding of his/her adoption/foster care/guardianship. At what age did your child learn about his/her adoption/foster care/guardianship? Hos your child expressed a desire to learn about the birth parents?

___

___

___

If your child has expressed the desire, do you support your child's interest or possible search for his/her birth parents?

☐ Yes ☐ No ☐ Don't know Explain:___

___

___

Please indicate if birth relative have had any of the following:

	Birth Mother	Birth Mother's Family	Birth Father	Birth Father's Family
Allergies				
Asthma/Emphysema				
Diabetes				
Heart Condition				
Mental Retardation				
Seizure Disorder				
Depression				
Schizophrenia				
Other Psychiatric disorders (explain)				
Learning Disability				
Behavioral Problems				
Alcohol/Drug Abuse				

Living Arrangements

Number of moves in child's life:___

Location **Dates** **Reason**

___

___

___

___

___

Current home: ☐ House ☐ Apartment ☐ Renting ☐ Own What year did you move into your current home?___

Does the child share a room with anyone else? ☐ Yes ☐ No If yes, with whom?:___

___

Living Arrangements (continued)

Please list information about the child's siblings below:

Name	Age	Sex	Living at Home?	Receiving Mental Health Services?	Drug or Alcohol Problems?	Birth/Adoptive/ Stepsibling/Other

Besides the child and the siblings above, who else lives in the family home at the present time?

Name	Age	Sex	Relationship to the Child	Receiving Mental Health Services?	Drug or Alcohol Problems?	Physical Illness

Is there anything else that would be important for us to know in order to best meet the needs of your child and your family?____