Parent to complete

CLIENT NAME:_____ **BIRTH DATE:**_____ **AGE:** ____

ADRESS: _____ **CITY:** _____ **ZIP:** _____

AME OF PARENT COMPLETING FORM: _____

Checklist Regarding Behavior & Mood of Your Child:

Check all that apply to your child	**BEHAVIOR**	
☐ Inattentive	☐ Annoys Others	☐ Not learning from mistakes
☐ Hyperactive	☐ Argumentative	☐ Serious Rule Violations
☐ Impulsive	☐ Negative/talks abusively to others	☐ Criminal Activity
☐ Destruction of Property	☐ Tantrums/Rage	☐ Blames Others
☐ Episodes of Violence/Aggression	☐ Social Withdrawal	☐ Self-Harm
☐ Appetite Issues	☐ Difficulty Sleeping	☐ Poor Concentration
☐ Fidgets	☐ Reckless Behavior	☐ Physical/Sexual Abuse
☐ Poor Self Care	☐ Nightmares	☐ Suicidal Ideation
☐ Relationship Problems	☐ Chem. Dependency Issues	☐ Runs Away / Truancy
☐ Bizarre Behaviors	☐ Inappropriate sexual advances or	☐ Physically or sexually assaultive-
☐ Others (describe)_____	behaviors	☐ actual ☐ threatened

Check all that apply to your child	**MOOD**	
☐ Excessive Worry	☐ Feelings of Worthlessness	☐ Separation Issues
☐ Bodily Complaints	☐ Depression	☐ Social isolation/withdrawal
☐ Mood Lability	☐ Loss of interest or pleasure	☐ Anxious
☐ Panic	☐ Low self-esteem	☐ Cries Easily
☐ Other (describe)_____	☐ Irritability	

What are your desired outcomes for therapy/evaluation?

What would you, your child, or family like to achieve as a result of receiving services from *David W. Clegg*
(Check all that apply to you/your child)

- ☐ Manage stress / emotions better
- ☐ Find / discuss medication that might help
- ☐ Improve relationships in the home between family members
- ☐ Become more independent / less dependent on people
- ☐ To return to work or do volunteer work
- ☐ Have fewer problems in the home, at school, or work
- ☐ Other (describe) _____
- ☐ Decrease depression & anxiety symptoms
- ☐ Manage behavior better
- ☐ Have better attendance at school
- ☐ Participate in more social activities
- ☐ Worry less
- ☐ Feel better about myself

Have you or your child (if client) ever had counseling/evaluation before? ☐ **No** ☐ **Yes**

Where or with Who? _____ When? _____

If yes, What Issues did you address?

_____

Parent to complete

Have you or child received help or services from any of these agencies? **(Check all that apply to you)**

- ☐ Special Education
- ☐ Catholic Community Services
- ☐ Chemical Dependency Treatment Provider
- ☐ Department of Corrections or Juvenile Justice
  If so, are you required by the court to get treatment or services? ☐Yes ☐No
- ☐ Developmental Disabilities
- ☐ Division of Vocational Rehab
- ☐ DCFS
- ☐ Tribal Services
- ☐ Home and Community Services
- ☐ Juvenile Court/Detention
- ☐ Other _____

SUBSTANCE USE ☐ *NA – No client substance use issues identified*

Have you or child (if client) used any of these substances in the past 12 months? **(Check all that apply)**

Substance	Date of Last Use	Substance	Date of Last Use
Alcohol		LSD	
Marijuana		Mushrooms	
Methamphetamine/Stimulants		Pain Killers	
Heroin/Opiates		Tobacco	
Inhalants		Caffeine	
Cocaine		Other	

Have you ever had treatment for substance use? ☐ No ☐ Yes

Dates of chemical dependency treatment _____ ☐ Outpatient ☐ Inpatient

Do you attend 12-Step or CD support groups? ☐ No ☐ Yes

Does you child have any medical problems now? **(Check all that apply to you)**

- ☐ Difficulty Sleeping
- ☐ Appetite Problems
- ☐ Weight Gain or Loss
- ☐ Memory Problems
- ☐ Trouble Concentrating
- ☐ Headaches
- ☐ Heart
- ☐ Lungs
- ☐ Diabetes
- ☐ Liver Problems
- ☐ Seizures
- ☐ Skin
- ☐ Stomach
- ☐ Joints
- ☐ Back Problems
- ☐ Allergies
- ☐ Bed Wetting
- ☐ Other (Describe) _____

MEDICATIONS: List all of your child's medications including those for emotional problems

Name of Medication	How Much?	How Often?	Date Last Taken	Reason for Taking?	Who Prescribed?

Medical Information:

Does your child have a medical doctor? ☐ **No** ☐ **Yes,** If yes, name of doctor or medical provider _____

Phone #: _____ Date of last physical examination: _____

Does your child have a specific diagnosed medical condition? ☐ **No** ☐ **Yes,** If yes, please explain:

_____

Does your child wear corrective lenses? ☐ No ☐ Yes Does your child have any hearing difficulties? ☐ No ☐ Yes

Has your child had a serious injury or illness requiring hospitalization? ☐ No ☐ Yes, If yes, please explain:

Parent to complete

Parent/Family Information:

☐ Mother's Name: _____ Age: _____ Occupation: _____

☐ Father's Name: _____ Age: _____ Occupation: _____

Mother's Education Level: _____ Father's Education Level: _____

My Child is living with: ☐ Both Natural Parents; ☐ Natural Mother; ☐ Natural Father; ☐ Foster Parents; ☐ Adoptive Parents
☐ Mother / Step-Father; ☐ Father / Step-Mother; ☐ Grandparents; ☐ Aunt/Uncle; ☐ Group Home
☐ Other: _____

Other Children or relatives living in the home: (Indicate age & relationship): _____

_____

Child/Family History/Adjustment Information:

As you recall the life events in your family over the last three (3) years, describe any situation which may have impacted family members:

☐ Divorce ☐ Death of a loved one ☐ Family illness
☐ Remarriage ☐ Loss of job ☐ Financial Stress
☐ Birth of a child ☐ Promotion ☐ Incarcerated Parent
☐ Relocation/Family Move ☐ Parent Deployment ☐ Other: _____

What do you consider to be the most stressful in your family at this time?

_____

What does your family do to relieve the stress?

_____

How would you describe your style of discipline when working with your child?

_____

Do you have any major discipline problems with your child? ☐ No ☐ Yes, If yes, give a few specific examples:

_____

School Information Regarding Your Child:

Name of School: _____ School District: _____

School contact: _____ School Phone: _____

How many different schools has your child attended? _____ Current Grade your child is in: _____

Has your child ever been unable to attend school or been absent for a period of time? ☐ No ☐ Yes, If yes, explain:

_____

Has your child ever repeated a grade? ☐ No ☐ Yes, If yes which grade: _____

Has your child ever received special education services? ☐ No ☐ Yes, If yes, date of last assessment: _____

Does your child have an Individual Education Plan ☐ No ☐ Yes Does your child have a 504 Plan ☐ No ☐ Yes

Handicapping Condition: _____

What Other Services does your child receive: ☐ OT/PT ☐ Speech ☐ Deaf Ed ☐ Preschool

How successful is your child in school? _____

Parent to complete

Pregnancy & Development History:

Was the pregnancy of your child considered normal? ☐ Yes ☐ No, if no, explain:_____

_____

Were there any complications at or shortly after birth? ☐ No ☐ Yes, if yes, explain:_____

_____

Were there any health problems identified in the first two years? ☐ No ☐ Yes, if yes, explain:_____

_____

Behavior Information:

Please rate your child on the following behavior by checking one of the box for each behavior.

Behavior	Not at All	Just a Little	Pretty Much	Very Much
Respectful to adults; Obeys adults				
Able to make & keep friends				
Controls excitement				
Cooperates with ideas of others				
Can wait for attention/rewards				
Adapts to new situations				
Tells the truth				
Comfortable in new situations				
Well behaved for age				
Is basically happy				
Completes what is started				
Considerate of others				
Maintains attention/focus				

Behavior	Not at All	Just a Little	Pretty Much	Very Much
Reacts with proper mood for situation				
Follows basic rules				
Settles disagreements peacefully				
Gets along with brothers/sisters				
Copes with frustration				
Tolerates criticism				
Can share attention of adults with others				
Is accepted by peers				
Accepts blame for own mistakes				
Able to "think" before acting				
Feels a part of the family				
Sleeps OK for age				
Shows leadership				