Shoreview Mental Health Center LLC
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PARENT QUESTIONNAIRE

In order to best be able to help you and your child, we need to know some things about your family. Please answer each question as completely as you can and explain any "yes" or "no" answers.

Background Information:

Client's Name: _____ Date of Birth: _____ Age: _____

Parents' Names:	Age	Education	Occupation	Biological Parent?
_____	_____	_____	_____	___
_____	_____	_____	_____	___

Sibling's Names:	Age	Education	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home? _____

Date(s) of marriage and/or divorce of parents: _____

If the client's biological parents are divorced, please fill in the following information:

Name of Parent	Date(s) of Marriage	Name of Step Parent
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal and Physical Custody / Visitation Arrangements:

History of Problem:

What is the problem / Why are you bringing your child in for evaluation?

When and how did you first notice the problem?

What kinds of changes have you seen in your child which seems to be a part of the problem?

How have you tried to resolve the problem?

Please describe any major incidents (such as moving, or the death of a family member) which seem to have affected your child. What was his/her reaction?

What other major changes have happened in the family (additions, losses, financial changes, moves, etc.)?

Family Interaction:

Describe your relationship(s) with the client's sibling(s):

What do you do together as a family?

How are decisions made in your family?

What kind of discipline is used in your family? Who is the "family disciplinarian"?

How does your family express feelings?

How often are there conflicts in your family? What are they usually about?

Family History:

What is your family cultural background (ethnic or racial origin, religion, etc.)?

Is there any history of medical illness (such as diabetes, cancer, renal disease, heart disease, glaucoma, etc.) in your family?

Please note any history of psychiatric illness (such as depression, learning disability, schizophrenia, manic depression, attention deficit, etc.) in your family?

Is there any history of alcohol and/or drug use or dependency in your family?

Please describe the history of your immediate family, including dates of births, marriages, divorces, major illnesses, moves, etc.:

Client's Developmental History:

Was the client a planned child? How did parent(s) react to the pregnancy?

Were there any complications during the pregnancy and/or birth of the client? If yes, please describe:

Please describe the client's emotional and behavioral adjustment (response, activity level):

as an infant: _____
as a toddler: _____
as a preschooler: _____
during grade school: _____
during junior high: _____
during high school: _____

At what age did the client:

say a single word _____ simple sentences _____ complete sentences _____
crawl _____ walk _____

At what age was the client::

bladder trained _____ bowel trained _____ interested in other children: _____

Were there any problems with toilet training? If yes, please describe:

Were there any problems with wetting or soiling the bed after the client had been toilet trained? If yes, please describe:

How well did the client tolerate normal separations before school age?

Please describe early eating and sleeping patterns:

as an infant: _____

as a toddler: _____

as a preschooler: _____

childhood / later years: _____

Have you noticed any unusual eating patterns (such as fasting, constant dieting, eating a lot at one time followed by not eating, etc.) or changes in the client's eating habits? If yes, please describe:

Educational History:

What school is the client enrolled in: _____ Grade: _____

How old was the client when he/she started school? _____

Has the client repeated or skipped any grades? ☐ No ☐ Yes: _____

Have there been any academic, behavioral, or emotional problems with peers or teachers? If yes, when did the problems begin and what were they?

What kinds of grades does the client usually get? Describe any recent changes.

Has the client ever been assessed for learning problems (LD/EBD) or been in special classes (chapter 1 or tutoring)? If yes, please describe:

Has the client ever been suspended or expelled from school? If yes, please describe why this happened and how you handled it:

Treatment History:

Has the client ever been taken to a mental health or chemical dependence professional before? If yes, please fill in the following information:

Name of Professional	Dates of Service	Reason for Services
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the client ever seen a school counselor or school psychologist? If yes, please explain, including the reason(s) and dates(s):

Has the client ever been placed out of the home for mental health, emotional and/or behavioral reasons (foster care, impatient treatment, residential treatment, juvenile detention, with relative, etc.): If yes, please explain:

Has anyone else in the family received psychiatric, psychological and/or chemical dependency treatment in an inpatient or outpatient setting? If yes, please explain:

How do you feel about seeking help for your child at this time?

What goal(s) do you have for the treatment of your child?

What educational material(s) have you read related to the problem area(s) for your child?

Miscellaneous: Is there anything else you'd like to share that has not been asked/answered already?