Dr. Darla Gilbert, LPC, LMFT
Rivers Mental Health Services
1403 Metro Drive
Alexandria, Louisiana 71303

PARENT QUESTIONNAIRE

(For parent to complete)

Contact Information:

Name of person completing this form: ______________________________
Child's name: ______________________________
Parent phone: (home) ______________
(work) ______________
(cell) ______________
Who referred you to us? ______________________________

What is your primary reason for your child's participation in counseling?
____
____

Family Information:

Child's mother: ______________________ Date of birth: __________
Address: ______________________________
City/State: ______________________ Zip: __________
Place of employment: ______________________________

Occupation: ______________________ Hours at work per week: __________

Child's father: ______________________ Date of birth: __________
Address: ______________________________
City/State: ______________________ Zip: __________
Place of employment: ______________________________

Occupation: ______________________ Hours at work per week: __________

Siblings:
Name: ______________________ Age: ______ Lives with: ________
Name: ______________________ Age: ______ Lives with: ________
Name: ______________________ Age: ______ Lives with: ________
Name: ______________________ Age: ______ Lives with: ________
Who is the child's legal guardian? ______________________________
(if different than parents')
Address: ______________________________
City/State: ______________________ Zip: __________

Phone: (home) ____________________________

(work) ____________________________

(cell) ____________________________

Who lives in the home with the child?

____

____

If parents are separated/divorced, what is the visitation schedule?

____

____

Does either parent currently have legal issues? ( ) Yes ( ) No

Explain: ____

____

Does either parent have a history of legal issues? ( ) Yes ( ) No

Explain: ____

____

Academic and Social Information:

Child's school: ____________________ Grade: _______ Teacher: ______________

Daycare: ____________________________ Days/Times at daycare: ______________

How does your child do in school academically?

____

____

How does your child do in school socially?

____

____

Does your child have a learning disability? ( ) Yes ( ) No If so, explain.

____

____

Does your child/family have any specific spiritual beliefs or affiliations?

____

____

Does your child/family attend church anywhere? If so, where and with what frequency?

____

____

Is your child involved in any extracurricular activities?

____

____

Circle any of the following that describe your child at this point in his/her life.

Active	Ambitious	Self-confident	Persistent	Nervous	Hard-working
Impatient	Moody	Often blue	Excitable	Imaginative	Calm
Serious	Easy-going	Shy	Good-natured	Introverted	Extroverted
Likable	Leader	Quiet	Phony	Lonely	Submissive
Cynical	Hopeless	Self-conscious	Optimistic	Sensitive	Alone
Frightened	Abandoned	Broken	Angry	Solid	Worthless
Desperate	Overweight	Ugly	At peace	Energetic	Guilty
Attractive	Afraid	Forgetful	Unorganized	Content	Stressed
Friendly	Betrayed	Mistrustful	Irritable	Distracted	Other:________

Are these descriptive words different now than usual? If so, please explain.

____

____

Are there things that your child used to do, or would like to do, but currently doesn't?
Explain. ____

____

Who would you say are the five most important people in your child's life?

____

____

Is there anything else you think would be important for your therapist to know about your child or your family history?

____

____

Medical History:

Primary Care Physician: ____________________ Phone: __________

Address: ____

City/State: ______________________________ Zip: ______________

Date of last physical exam: ____________________________________

Other physicians: Please include name, specialty, and city

____

____

____

____

Please list all medications, duration, amount taken, and prescribing physician.

Please list any health concerns or diagnoses for which your child is now being treated.

Does your child have any medical allergies? Other allergies?

Has your child recently lost or gained weight not typical of normal development? How much? Over what period of time?

How many hours of sleep does your child get per night? Does your child have difficulty falling asleep or waking?

During pregnancy, did the mother use: ( ) Cigarettes ( ) Drugs ( ) Alcohol ( ) Have extreme stress; List any birth complications:

List any medical conditions in your child's history: (surgeries, broken bones, loss of consciousness, etc.)

Did your child reach developmental milestones: ( ) Early ( ) On time ( ) Delayed

Does your child use: ( ) Cigarettes ( ) Drugs ( ) Alcohol

Counseling History:

Has your child experienced any of the following? (circle all that apply)

Separation from mother	Separation from father	Out-of-home care	Depression of mother
Depression of father	Physical abuse	Sexual abuse	Emotional abuse
Neglect	Cutting	Substance abuse	Eating disorder
Childhood depression	Chronic illness	Academic difficulties	Divorce of parents
Alcoholism in home	Death of close relative: ______________________	Verbal abuse	Other:________________ ______________________

Has your child ever seen a counselor before? ( ) Yes ( ) No If so, please list.

Name Date City/State Approximate # of visits

____

____

Was counseling a positive experience for tour child? What did your child like/not like about counseling?

____

____

Has your child ever mentioned suicidal thoughts? ( ) Yes ( ) No

Has your child ever attempted suicide? ( ) Yes ( ) No

Date(s):_________________________________

Has your child ever been hospitalized for mental health treatment ( ) Yes ( ) No If so, please list

Name Date City/State

____

____

Has your child witnessed domestic violence? ( ) Yes ( ) No Explain:

____

____

How many times has your child moved? _____________________________________

Has your child been verbally abused? ( ) Yes ( ) No ( ) Suspected Explain:

____

____

Has your child ever been sexually abused? ( ) Yes ( ) No ( ) Suspected Explain:

Has your child ever been physically abused? ( ) Yes ( ) No ( ) Suspected Explain:

Please circle any of the following symptoms your child has.

Anger	Anxiety	Bed-wetting	Acts out sexually with others	Behavior problems
Controlling	Day defecation	Has unusual/explicit sexual knowledge	Day wetting	Defiance
Depression	Homicidal thoughts or actions	Disassociates	Drug/alcohol use	Hyperactivity
Masturbates excessively	Hypervigilance	Lack of empathy	Lethargy	Lack of consciousness
Lack of motivation	Low self-esteem	Lying	Plays out sexual themes	Low impulse control
Nightmares	Night terrors	Plays out violent themes	Obsesses	Overeats
Peer problems	Phobias	Running away	Shy	Sleeplessness
Startles easily	Stealing	Tantrums	Under eats	Headaches/ stomachaches

What are your child's hobbies?

What are your child's strengths?

What are your goals for your child's therapy?

Do you have any questions that you would like me to answer?