Lisa Alber, LICSW Tel 978-866-1435

CHILD – ADOLESCENT - PARENT QUESTIONNAIRE

Today's Date:_____ Form Completed By: _____ Relationship to Child: _____

Child's Name: _____ Date of Birth: _____ Age:_____ Gender: F M

Address: _____ City: _____ State:_____ Zip: _____

Home Phone : _____ Parent Work Phone:_____ Cell/Other: _____

Child Cell: _____School: _____ Grade:____ Primary Teacher:_____

Primary Health Insurance Company: _____ ID: _____ Group #: _____

Provider Services Tel # (back of card) _____ Subscriber Name: _____

Subscriber DOB: _____ Relationship to Client: _____ Subscriber Employer: _____

Secondary Health Insurance Company: _____ ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship to Client: _____

PRESENTING ISSUES:

Why you have chosen to have your child receive counseling at this time **and/or** what are the goals for your child?

_____

Do any of the following apply to your child? __ other _____

__unhappy	__anxious/worries	__poor concentration	__peer conflicts	__destructive
__irritable	__withdrawn	__overactive	__caffeine use	__legal problems
__low self-esteem	__fearful/phobic	__daydreams	__drug use	__sexual promiscuity
__anger outbursts	__nausea	__unmotivated	__alcohol use	__blames others
__self-harm	__panic attacks	__impulsive	__lying	__disrespectful
__suicidal thoughts	__heart racing	__inflexible	__stealing	__recent behavioral changes
__suicidal gestures	__head banging	__distractible	__fire setting	__nightmares
__eats less/more	__mood swings	__compulsive behaviors	__runs away	__ wets/soils pants
__sleeps less/more	__talks excessively	__racing thoughts	__bullies others	__binging or purging
__ low energy	__tearful	__obsessive thoughts	__physically cruel to people or animals	
__trauma history	__family conflict	__family member ill	__ death in family	__ parent in military

How long have these issues existed? (# weeks, months, years) _____

Is there anything you think may have lead up to your child's difficulties? _____

In Case of Emergency, notify: _____ Relationship to Child: _____

Tel # _____Cell # _____ Is person aware child is seeking services? Y ____N ____

Please note that by providing Lisa Alber, LICSW with this emergency information, you are giving permission to contact this person at any time in which Lisa Alber, LICSW has determined the above client is in an emergency situation.

FAMILY HISTORY:

Parent #1

Relationship to Child: __Birth Parent __Adoptive Parent __Step-Parent __Relative __Other (explain)

Name: _____ __ Female __ Male Date of Birth: _____ Age: _____

Address: _____ Tel # _____

Live with Child: Yes No Do you have legal custody of this child? Yes No

Place of employment: _____ Occupation: _____

Parent #2

Relationship to Child: __Birth Parent __Adoptive Parent __Step-Parent __Relative __Other (explain)

Name: _____ __ Female __ Male Date of Birth: _____ Age: _____

Address: _____ Tel # _____

Live with Child: Yes No Do you have legal custody of this child? Yes No

Place of employment: _____ Occupation: _____

Note: Where one parent has FULL legal custody, please provide copy of legal document.

Are child's biological parents married? Y N If no, Date of Divorce/Separation/Break Up _____

Siblings: List name, age, gender and relationship (include birth, step, half, and adopted siblings)

Name	Age	Gender	Relationship	Lives with Child	If no, where do they live?
_____	_____	F M	_____	Yes No	_____
_____	_____	F M	_____	Yes No	_____
_____	_____	F M	_____	Yes No	_____
_____	_____	F M	_____	Yes No	_____

Deceased Sibling(s): Yes No Please explain _____

Number of moves in child's life: _____ Current Home: __ House __ Apartment __Rent __ Own __ Other

What year did you move there? _____ Does the child share a room. Yes No If yes, with whom? _____

Where did your child live prior to this location? _____

Is there a firearm and/or weapon in your home? Yes No What? _____

Are there any concerns regarding the safety of your child? _____

Does child live with someone who has a drug or alcohol addiction? Yes No Who? _____

PSYCHIATRIC AND HEALTH HISTORY:

Has your child received counseling services before? Yes No

Dates: _____ Provider: _____ Phone: _____

Has your child ever been hospitalized for psychiatric symptoms? Yes No

Date of Hospitalization: _____ Hospital: _____ Reason for Hospitalization: _____

Please list all **current psychiatric** medications:

Medication/Dose: _____ Prescriber: _____

Does your child know you are seeking therapy for them? Yes No

Why does your child think they are coming for therapy? _____

How does your child feel about attending therapy? _____

Please indicate with a √ child and family history

	Child	Birth Mother	Birth mother's Family	Birth Father	Birth Father's Family	Siblings (name)	Other Relative (name)
ADD/ADHD							
Alcohol or Drug Abuse							
Anxiety							
Asperger's / Autism							
Behavioral Problems							
Bipolar							
Depression							
Eating Disorder							
Learning Disability							
Mental Retardation							
OCD							
PTSD							
Schizophrenia							
Trauma History							
Other (explain)							

MEDICAL

Child's Primary Care Physician: _____ Tel # _____Date of Last Physical_____

Any allergies? Y N Please list _____

Please list all **non-psychiatric** medications? _____

Current illnesses and/or physical limitations: _____

SCHOOL HISTORY:

Does your child receive counseling in school? Yes No Does your child like school? Yes No

Is your child having difficulties in school? Yes No Has there been a recent drop in grades? Yes No

Is your child refusing to attend school or is often late? Yes No Has there been a recent change in behavior? Yes No

Does your child receive tutoring? Yes No With whom? _____

Does your child have learning difficulties? Yes No What kind? _____

Does your child have an IEP or 504 Plan? Yes No Which one? _____

Are current psychiatric issues interfering with your child's ability to attend school? Yes No

Explain: _____

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

_____

SOCIAL HISTORY:

Hobbies/interests/sports: _____

Does your child have a best friend? Yes No If yes, list first name only _____

Do you think this friendship is healthy? Yes No If no, please explain: _____

What are your child's strengths? _____

Does your child have any pets? If yes, please list names: _____

Does your child get regular exercise or play a sport? Yes No _____

Has your child ever been employed? Yes No List employer and duration: _____

Has your child ever experienced physical, emotional, or sexual abuse? Yes No If yes, please explain:

_____

Has your child ever had a traumatic or frightening experience? _____

Do you have any concerns about your child's social life? _____

LEGAL HISTORY: (DCF – Department of Children and Families)

Is DCF currently involved? Yes No Please explain: _____

DCF: Office: _____ Worker: _____

Has there been court involvement? If so, why? _____

Has/Does your child have difficulty with authority figures or had a situation which resulted in police contact? Yes No

_____

Additional Comments: _____

_____

Thank you for taking the time to complete this important assessment.