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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: _____

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

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

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	__ parent in military	__ physically cruel to people
__trauma history	__family conflict	__family member ill	__ death in family	or animals

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

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

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 # _____

Email Address: _____

Do you live with this 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 # _____

Email Address: _____

Do you live with this 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: (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 this child live with someone who has a drug, alcohol or other addiction? Yes No Who? _____

Have there been any changes in the home or family situation? _____

Are there conflicts between family members? _____

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: _____

Have there been any development delays or childhood diagnosis/illnesses? Y N

_____

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? _____	
Does your child see the school nurse frequently?	Yes No	If so, what do they think is going on?	

_____

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. 9/2014