

PARENT QUESTIONNAIRE

Date \_\_\_\_\_ Form Completed By \_\_\_\_\_

Child's Full Name \_\_\_\_\_ Gender \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
Street City State County Zip

Who referred the child? \_\_\_\_\_ Child's Primary Physician \_\_\_\_\_

Parent 1: \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

E-mail address \_\_\_\_\_

Home Phone \_\_\_\_\_ Can we leave a message w/a person? Y/N voice-mail? Y/N

Cell Phone \_\_\_\_\_ Can we leave a message w/a person? Y/N voice-mail? Y/N

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Educational Level \_\_\_\_\_

Work Phone \_\_\_\_\_ Can we leave a message w/ a person? Y/N voice-mail? Y/N

Parent 2: \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

E-mail address \_\_\_\_\_

Home Phone \_\_\_\_\_ Can we leave a message w/a person? Y/N voice-mail? Y/N

Cell Phone \_\_\_\_\_ Can we leave a message w/ a person? Y/N voice-mail? Y/N

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Educational Level \_\_\_\_\_

Work Phone \_\_\_\_\_ Can we leave a message w/ a person? Y/N voice-mail? Y/N

Marital Status \_\_\_\_\_ If parents are separated or divorced: Separation/Divorce Date \_\_\_\_\_

With whom does the child live?  Birth parents  Adoptive parents  Foster parents  
 Grandparents  Other \_\_\_\_\_

Who has physical custody? \_\_\_\_\_ Legal custody? \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Member ID/Policy Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

**Note: Please complete all information on this report. All information is treated in confidence and will not be released without your permission.**

List all other persons living in the home:

Name:	Age:	Relationship to Child:	Present Health:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any other people who care for the child a significant amount of time:

Name:	Relationship to Child (grandmother, neighbor, etc.):
_____	_____
_____	_____

Has social services ever been involved with your family? [ ]Yes [ ] No: If yes, please elaborate:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **CHILD**

Pregnancy and Birth: Any Complications? [ ]Yes [ ] No: If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Developmental Milestones: (Ages) Sitting: \_\_\_\_\_ Walking: \_\_\_\_\_ Toilet Trained: \_\_\_\_\_

Speak First Words: \_\_\_\_\_ Use 2-3 Word Phrases: \_\_\_\_\_ Full Sentences: \_\_\_\_\_

Medical Problems: [ ]Yes [ ] No; If yes, briefly explain: \_\_\_\_\_

\_\_\_\_\_

Child's Last Physical Exam Date & Results: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

FAMILY RECORD  Check (✓) condition and relationship of any blood relative who has or has had any of the conditions listed below:	N O N E	C L I E N T	B I O - F A T H E R	B I O - M O T H E R	G R A N D F A T H E R	G R A N D M O T H E R	B R O T H E R	S I S T E R	S O N	D A U G H T E R	O T H E R	I N D I C A T E  O T H E R  R E L A T I V E
Alcoholism/Substance Abuse												
Allergies												
Birth Defects												
Cancer												
Colitis												
Depression												
Anxiety												
Heart Attack												
High Blood Pressure												
Kidney Disease												
Liver Disease												
Migraines												
Mental Illness												
Seizure Disorder												
Mental Retardation/Intellectual Disability												
Autism/Asperger's												
Developmental Disability												
Learning Disorder												
Attention Problems												
Suicide/Suicide Attempt												
Thyroid Problems												
Eating Disorder												

Family Member	Living?	Age	Current Health:			If Deceased, Cause of Death
			Good	Fair	Poor	
Parent 1						
Parent 2						
Brothers						
Sisters						

Please list any jobs or chores your child has at home or at school. (For example, feeding the dog, making the bed, hall monitor)

How well does your child do these jobs?

<input type="checkbox"/> None	Poor		Average		Great
1. _____	1	2	3	4	5
2. _____	1	2	3	4	5
3. _____	1	2	3	4	5

What are your child's strengths? \_\_\_\_\_  
\_\_\_\_\_

How many close friends does your child have?  None  1  2  3  4 +  
How many close friends in the neighborhood does your child have?  None  1  2  3  4 +  
How many times/week does your child do things with them?  None  1  2  3  4 +

Compared to other children his/her age, how does your child get along with other children? Poor 1 2 Average 3 4 Great 5

What are your child's favorite recreational or extracurricular activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who generally disciplines the child? \_\_\_\_\_ What methods are used? \_\_\_\_\_  
\_\_\_\_\_

Do parents agree on methods of discipline?  Yes  No; If no, please elaborate: \_\_\_\_\_  
\_\_\_\_\_

## SCHOOL HISTORY

Has child been enrolled in a nursery or day care?  Yes  No At what age? \_\_\_\_\_

At what age did he/she enter first grade? \_\_\_\_\_ What is present grade placement? \_\_\_\_\_

If your child has ever been to school (including nursery, kindergarten, and grade school) complete the following for all grades beginning with nursery and ending with current placement. Please indicate if your child repeated or is in a special class (gifted/talented, learning disabled, behavior disordered, emotionally handicapped, etc.)

Grade	School	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current school performance (for children aged 6 and older):

Does not go to school

	Failing	Below Average	Average	Above Average
a. Reading				
b. Writing				
c. Math				
d. Spelling				
e. Other academic subjects (history, science, foreign language, geography, etc.)				

**PARENTAL CONCERNS**

What do you feel is your child's main problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you feel caused your child's problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What have you been told by doctors, teachers, and/or others about your child's problems? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any previous mental health evaluations, treatment, or diagnosis? If yes, by whom? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has any other member of your child's immediate family had mental health treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_