PARENT QUESTIONNAIRE FOR CHILD PATIENTS

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Please complete the following questionnaire prior to your child's first appointment. Please try to answer all of the questions relevant to your child to the best of your ability. Please note that this is a general questionnaire for parents of children *and* parents of adolescents. You may omit questions that are not applicable to your child based on his/her age or developmental ability. Your therapist will follow up with you on particular items if he or she has any questions. Thank you very much for taking the time to complete this form.

Date: ___________ **Referred By:** _________________________

Child's Full Name: ______________________________**Age:** ________**DOB:** __________**Sex:** _____

Height: _____________ **Weight:** ____________

Form Completed By: _______________________**Your Home Ph:** ________________________

Your Cell Ph: ______________________**Your Email:** __________________________________

PRESENTING PROBLEM

1. Briefly describe your child's problem or concern that you most wish help with currently: ____________

____

____

2. How would you rate the intensity of the problem or concern that led you to seek professional services?

Not Intense		Somewhat Intense		Very Intense
1	2	3	4	5

3. Approximately how long has your child had the current problem or concern? _______________

4. In what ways have you or your child attempted to cope with this problem or concern? _______________

____

____

CULTURAL BACKGROUND

5. What is your child's race/ethnicity?

□ White (non-Hispanic/Latino)
□ Hispanic/Latino
□ Black/African American
□ Asian American
□ American Indian/Alaska Native
□ Native Hawaiian/Pacific Islander
□ Multiracial (please specify): ___________________________________
□ Other (please specify): ___________________________________

6. Your family's religious or spiritual preference: ___________________________

7. Is your family currently active in your religion? ___________________

FAMILY BACKGROUND

8. Please list the members of your child's immediate family

	Name	Sex	Age	Adopted (Y/N)	Occupation	Education	Medical, Social, or School/Work Problems
Father							
Mother							
Sibling							
Sibling							
Sibling							
Sibling							
Sibling							

9. Marital status of child's parents: □ Single □ Married (Date)______ □ Divorced (Date) ____

10. Describe your and your spouse/partner's relationship with your child: ______________________________

____

____

____

11. Who is responsible for discipline in the home: ____

12. What types of discipline methods are used: ____

13. **If parent’s differ in discipline methods, how so:** ____
____
____

SOCIAL INFORMATION

14. **Does your child have friends?** □ yes □ no **How many**: __________

15. **How many times per week does your child do things with his/her friends:** ______

16. **Describe your child’s interactions with other children:** ____________________________________
____

17. **Does your child have difficulty initiating and/or maintaining friendships?** □ yes □ no
If yes, explain: ____
____

18. **Describe any undesirable social traits:** ____

19. **How does your child spend his/her leisure time:** ______________________________________

MEDICAL INFORMATION

20. **Describe your child’s overall health:** ____

21. **Your child’s primary physician’s name:** ____

22. **Please list any other physician’s names and type:** ___________________________________
____

23. **When was your child’s last physical exam:** ____________________

24. **Describe any delays in development:** ____
____

25. **How is your child’s vision/hearing:** ____

26. **List any allergies:** ____

27. **Is your child currently experiencing any physical pain?** □ yes □ no
If yes, which parts of his/her body are in pain? ____

28. **On a scale of 1 – 10, with 10 being excruciating pain and 1 being mild pain, how would you rate the pain?** ____
Is this pain: Constant?____ Intermittent?____ Occasional? ______

29. **Check if your child is currently experiencing any of the following symptoms:**

	Never	**Rarely**	**Frequently**	**Very Often**
Diarrhea	_______	_______	_______	_______
Constipation	_______	_______	_______	_______
High blood pressure	_______	_______	_______	_______
Heart Problems	_______	_______	_______	_______
Nausea	_______	_______	_______	_______
Vomiting	_______	_______	_______	_______
Headaches	_______	_______	_______	_______

Describe any other symptoms and rate how often they occur: ______________________________________

____

30. **Has your child ever been diagnosed with (please circle):**

Cancer Y N	Heart Problems Y N
Diabetes Y N	High blood pressure Y N
Asthma Y N	Ulcers Y N
Stomach Problems Y N	Seizures Y N
Epilepsy Y N	Fibromyalgia Y N
Sleep Apnea Y N	Stroke Y N
	Chronic Fatigue Syndrome Y N

List any other medical diagnoses: ____

31. **Have your child ever injured their head?** □ yes □ no

32. **Has your child ever lost consciousness?** □ yes □ no

33. **Is your child having any problems with his/her sleep habits?** □ yes □ no
If yes, check where applicable:
□ sleeping too little □ poor quality sleep
□ sleeping too much □ disturbing dreams
□ other ____

34. **How many times per week does your child exercise?** ___________ **For how long?** ___________________

35. **Is your child having any difficulty with appetite or eating habits?** □ yes □ no
If yes, check where applicable:
□ eating less □ binge eating
□ eating more □ restricting calories
□ significant weight change (in past two months) □ picky eating

MENTAL HEALTH HISTORY

36. **Has your child ever received a mental health diagnosis (i.e. ADHD, Autism, Oppositional Defiant Disorder, etc) (if so, list):** ____

37. **Is your child currently receiving psychiatric services, professional counseling, or therapy elsewhere?**
□ yes □ no

38. **Has your child ever had previous counseling or psychotherapy?** □ yes □ no
If yes, please specify the following:

Reason for counseling:____

Counseling location: ____

Counseling date: ____

Counseling duration: ____

What did you or your child like most about the counseling: ______________________________

____

What did you or your child like the least: ____

____

39. **Has your child ever received psychological testing?** □ yes □ no
If yes, please specify the following:

Reason for testing:____

Testing location: ____

Counseling date: ____

Testing results: ____

40. **Has your child ever been hospitalized for psychiatric reasons?** □ yes □ no
If yes, please specify the following:

Reason for hospitalization: ____

Hospital location: ____

Dates of hospitalization: ____

Duration of hospitalization: ____

41. **List all prescription medication your child is taking (psychiatric and non-psychiatric):**

Name	Dosage	Frequency	Date first prescribed	Prescribing physician

42. **Has your child had suicidal thoughts recently?** □ yes □ no □ unsure
If yes, how often?
□ daily □ weekly □ monthly □ rarely

43. **Has your child had suicidal thoughts in the past?** □ yes □ no □ unsure
If yes, how often?
□ daily □ weekly □ monthly □ rarely

44. Has your child ever intentionally inflicted harm upon him/herself? □ yes □ no □ unsure
If yes, how often?
□ daily □ weekly □ monthly □ rarely

Nature of harm: ____

45. Has your child ever intentionally hurt someone else? □ yes □ no □ unsure

Nature of harm: ____

46. Does your child get anxious about things? □ yes □ no □ unsure

If yes, what? ____

47. Does your child currently use drugs? □ yes □ no □ unsure

If yes, how often?

□ daily □ weekly □ monthly □ rarely

What does he/she use? ____

48. Has your child ever used drugs? □ yes □ no □ unsure

If yes, when? ____________

What did he/she use? ____

49. Has your child ever experienced any form of traumatic experience? □ yes □ no □ unsure

When? ____

Nature of experience: ____

50. Has your child ever experienced sexual assault, unwanted sex, or uncomfortable touching?
□ frequently
□ a few times
□ once
□ never
□ unsure

SCHOOL/ACADEMIC INFORMATION

51. Name, address, and phone # of child's school: ____

____

52. Grade: __________ **Teacher's name:** ________________________________

53. Does child enjoy school: □ yes □ no Explain: ____

____

54. How are your child's grades overall: □ good □ average □ poor

OTHER INFORMATION

55. What are your child's strengths: ____

____

56. What are your child's greatest areas of accomplishments: ____

____

57. What does your child like the most: ____

____

58. What does your child dislike the most: ____

____

59. Describe your child's personality: ____

____

60. What do you like best about your child: ____

____

61. What do you hope for your child to accomplish through counseling? ____

____

62. Is there anything else you would like me to know about your child? ____

____

____

Thank you for taking the time to fill out this questionnaire! Please bring it with you to your first appointment.