Child and Adolescent - Parent Questionnaire

Please answer the following questions as completely as possible.

Child’s Name:__________________________________________ M ____ F ____ Birthdate_________

Today’s Date: ____________ Form Completed By: ____________________________

Your Relationship to the Child: __________________________________________________________

Child’s School: _________________________________________Grade: _____ Age: _____

Child’s Primary Healthcare Provider: _______________________________ Phone _________________

When did your child last see their primary healthcare provider? __________ Reason?
___________________________________________________________________________________
___________________________________________________________________________________

Does or has your child had any chronic or serious illness? If so, please describe:
___________________________________________________________________________________
___________________________________________________________________________________

List any medications your child is taking, or has taken, on an ongoing basis:

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<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Start Date</th>
<th>MD</th>
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Has your child ever been hospitalized? If yes, briefly explain:
___________________________________________________________________________________
___________________________________________________________________________________

Family Information:
Mother’s Name:_________________________________________ Date of Birth: __________________

Mother’s Occupation: ______________________ # Hrs Works: _________ Education: ____________

Living in Home? If no, please explain:
___________________________________________________________________________________
___________________________________________________________________________________

Father’s Name: _________________________________________ Date of Birth: __________________

Father’s Occupation: ________________________ # Hrs. Works ________Education:_______________

Living in Home? If no, please explain:
___________________________________________________________________________________
___________________________________________________________________________________

With whom does the child live? Birth Parents _____ Step Parents ________ Grandparents ________
Other (Specify):
___________________________________________________________________________________

Living arrangement schedule, if applicable:
List all other persons living in the home:

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<th>Name</th>
<th>DOB</th>
<th>Relationship to Child</th>
<th>Sex</th>
<th>Grade/Job</th>
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List all other people who care for your child a significant amount of time (neighbor, babysitter, grandparent, etc.)

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<tr>
<th>Name</th>
<th>Relationship To Child</th>
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PARENT CONCERNS:

What is your primary concern about your child?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

When did this concern begin?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What do you think may have contributed to your child’s issues?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What have you been told by doctors, teachers and/or others about your child?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Has this child been seen by any other mental health professionals? If yes, for what reason and when?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Has this child had any educational evaluations, occupational or physical therapy, or speech or language evaluations?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Has any other member of the child’s immediate family had mental health treatment? Specify:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please describe any marital or family stresses which may contribute to your concerns about your child:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What has been done so far to address your concerns about your child?

____________________________________________________________________________________
Has your child experienced any changes or losses in his/her life that may be related to the concerns you have?
____________________________________________________________________________________
____________________________________________________________________________________

Please list any special strengths or talents that your child has:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

CHILD'S DEVELOPMENTAL HISTORY:

Pregnancy and birth, any concerns? No _____ Yes _____ If yes, explain briefly:
___________________________________________________________________________________

Child's Birth Weight: _________________ Gestational Age: ______________

Was The Child Adopted? _____ If Yes, at what age? _______

What History/Information Is Known About The Birth Parents? ________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Developmental Milestones (early, average, or late?)

Sitting ____________ Walking _____________ Talking _____________ Toilet Trained ___________

Early Medical/Developmental Concerns? No _____ Yes _____ If Yes, Briefly Explain: _____________
____________________________________________________________________________________

When interacting with peers, would your child can be described as:
___ Withdrawn ___ Disinterested ___ Assertive ___ Aggressive
___ Friendly ___ Thoughtful ___ Leader

What are your child's favorite recreational interests and hobbies?
________________________________________________________________________________

Extracurricular activities None _____ Yes ___ Which ones?
________________________________________________________________________________

Who generally disciplines the child?
________________________________________________________________________________

What methods are used?
________________________________________________________________________________

Do parents agree about method of discipline? No _____ Yes _____ If No, Please Explain:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Please list any jobs or chores your child has in the family or at school and how well these jobs or chores are performed? (e.g. feeding the dog, taking out trash) None

1. ________________________________________ ________________________________

2. ________________________________________ ________________________________

3. ________________________________________ ________________________________

**SCHOOL HISTORY:**

Has your child been enrolled in preschool or daycare? ___________ What age? ___________

Has your child attended kindergarten? ___________ What age? ___________

Has child your begun elementary school? ______

At what age did he/she enter first grade? ______

____________________________________________________________________________________

Please comment if your child repeated a grade or is in a special class (gifted, learning-disabled, behaviorally/emotionally handicapped, etc.)

504 Plan/IEP, currently or in the past? Yes _____ No_______

What accommodations are being provided?

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

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<th>Failing</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
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<td>READING</td>
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<tr>
<td>SPELLING</td>
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Behavior concerns in school?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

**Problem Checklists:** Please *circle* any of the following problems your child has:

- Doesn’t pay attention
- Refuses to obey
- Is a bully
- Doesn’t listen
- Deliberately annoys
- Fights
- Doesn’t finish things
- Blames others
- Uses weapons
- Distractible
- Irritable
- Cruel to people
- Disorganized
- Angry
- Cruel to animals
- Forgetful
- Spiteful
- Forces sexual activity
- Hyperactive
- Uses drugs
- Sets fires
- Fidgety
- Uses alcohol
- Property destruction
- Doesn’t stay in seat
- Uses tobacco
- Lying
- Noisy
- Sexually active
- Running away
- Can’t sit still
- Other high-risk behaviors
- Stealing
- Talks excessively
- Gang involvement
- Impulsive
- Breaking curfew
- Interrupts
- Truancy
- Loses temper easily
- School suspension
- Avoids homework
- Police called due to behavior
- Probation program
- Juvenile hall detention
Consequences don’t work
Poor conscience
Inconsistent appetite
Hoards food
Hides things
Fascinated by destruction
Demanding
Clingy
Tries to be cute
Splits parents
Too shy
Too worried
Indecisive
Aloof

Superficial
Manipulative
Inconsistent eye contact
Indiscriminately affectionate
Hugs strangers
Not cuddly
Sneaky
Wants own way or no way
Controlling
Leaves trail of destruction
Distorts truth

Depressed
Not interested in doing fun things
Weight change: ___ more ___ less
Appetite change: ___ more ___ less
Sleep change: ___ more ___ less
Agitation
Fatigue
Feels worthless
Feels guilty
Poor concentration
Indecision
Crying spells

Wets self: ___ day ___ night
Soils self: ___ day ___ night
Smears bowel movements
Picks at self
Pulls hair out

Physical abuse
Sexual abuse
Mental abuse
Neglect
DYFS involvement

Thoughts of death
Thoughts of suicide
Suicide plan
Suicide attempt

Doesn’t want to eat
Binges
Throws up
Uses laxatives for weight loss
Feels fat
Feels ugly

Is there anything else you would like me to know?

Thank you for taking the time to complete this evaluation.