COGNITIVE THERAPY & CONSULTATION, LLC

Date:_____

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:

Name	*Dosage*	*Frequency*	*Start Date*	*MD*

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:

Name *DOB* *Relationship to Child* *Sex* *Grade/Job*

_____
_____
_____
_____
_____

List all other people who care for your child a significant amount of time (neighbor, babysitter, grandparent, etc.)

Name *Relationship To Child*

_____
_____

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 __

POOR (1) AVERAGE (3) GREAT (5)

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):

	Failing	Below Average	Average	Above Average
READING	_____	_____	_____	_____
WRITING	_____	_____	_____	_____
MATH	_____	_____	_____	_____
SPELLING	_____	_____	_____	_____

Behavior concerns in school?

_____
_____
_____
_____

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

Doesn't pay attention
Doesn't listen
Doesn't finish things
Distractible
Disorganized
Forgetful
Hyperactive
Fidgety
Doesn't stay in seat
Noisy
Can't sit still
Talks excessively
Impulsive
Interrupts
Loses temper easily
Avoids homework

Refuses to obey
Deliberately annoys
Blames others
Irritable
Angry
Spiteful
Uses drugs
Uses alcohol
Uses tobacco
Sexually active
Other high-risk behaviors
Gang involvement

Is a bully
Fights
Uses weapons
Cruel to people
Cruel to animals
Forces sexual activity
Sets fires
Property destruction
Lying
Running away
Stealing
Breaking curfew
Truancy
School suspension
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

Thoughts of death
Thoughts of suicide
Suicide plan
Suicide attempt

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

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.