

### PARENTAL QUESTIONNAIRE (Children & Adolescents)

The information requested on this form serves two purposes. It allows us to learn many things about you and your background in a way that we can more clearly understand the reasons you have for coming in. It also allows us to gather information we are required to have by our accrediting organization, but may or may not be important to you. While we recognize that this will take time to complete, it ultimately saves you time with your clinician, so that you can pay more attention to the concerns that bring you in. Thank you for your cooperation and participation.

Name of Person Completing Form: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Child's Name:	Birth Date:	Age:	Race:	Sex:
Child's School:	Grade:	Teacher's Name:		
If parents are not married, who has legal custody of child?				
Adult(s) child is presently living with: (siblings should be listed on next page)				
<input type="checkbox"/> Biological Mother	<input type="checkbox"/> Biological Father	<input type="checkbox"/> Step Mother	<input type="checkbox"/> Step Father	
<input type="checkbox"/> Adoptive Mother	<input type="checkbox"/> Adoptive Father	<input type="checkbox"/> Foster Mother	<input type="checkbox"/> Foster Father	
<input type="checkbox"/> Grandparents	<input type="checkbox"/> Other (specify) _____			
Non-residential adults involved with this child on a regular basis:				
Who referred you to our services? Name/Address/Phone:				
Briefly state your main concerns with this child:				
Are you aware of, or do you suspect <u>any</u> drug use, consumption of alcohol, or inhalation of chemicals? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**Previous Behavioral Health Treatment:**

Please indicate any previous treatment you have received for mental health or substance abuse problems:

Approximate Dates	Type of Treatment	Institution/Provider	Problem for which you sought help	How helpful was your care?

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**PARENTS**

<b>Mother's Name:</b>		Age:	Age at time of pregnancy:
Mother's Occupation:		Business Phone:	
	<u>Past</u>	<u>Current</u>	
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Drug or Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/mental Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Father's Name:</b>		Age:
Father's Occupation:		Business Phone:
	<u>Past</u>	<u>Current</u>
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>
Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/mental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>

Have any other blood relatives (grandparents, uncles, aunts, etc.) had any of the following problems?		
	<u>Past</u>	<u>Current</u>
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>
Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>
Emotional/mental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>

**CHILD'S SIBLINGS**

	Name	Age	Medical, Social, or School Problems
1.			
2.			
3.			
4.			
5.			
6.			

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**PREGNANCY** – Complications

- Excessive vomiting
- Excessive staining/blood loss
- Hospitalization or bed rest required
- Threatened miscarriage
- Toxemia
- Smoking during pregnancy \_\_\_\_\_ # of cigarettes per day
- Infection(s) (specify) \_\_\_\_\_
- Operation(s) (specify) \_\_\_\_\_
- Other illness(es) (specify) \_\_\_\_\_
- Describe alcohol consumption during pregnancy (amount, frequency) \_\_\_\_\_
  
- Medication taken during pregnancy \_\_\_\_\_
- Other drugs used during pregnancy \_\_\_\_\_
- Duration of pregnancy (check one)     Early             Normal             Late

**DELIVERY**

- Type of Labor:             Spontaneous     Induced     Duration (hrs.) \_\_\_\_\_
- Type of Delivery:         Normal             Breech         Caesarean

**POST DELIVERY PERIOD**

- Jaundice                     Cyanosed (turned blue)             Incubator Care
  - Infection (specify) \_\_\_\_\_
- Number of days infant was in hospital after deliver \_\_\_\_\_            Birth weight \_\_\_\_\_

**BEHAVIORAL PATTERNS:** (Please check any of the following that have either been a problem in the past or are a problem currently)

	Past	Current
Clingy		
Irritable		
Mood swings		
Refusing to eat		
Inducing vomiting		
Hoarding food		
Over eating		
Overly active		
Under active		
Afraid of others		
Shy		
Easily frustrated		
Tantrums		
Aggressive behavior		
Cruel to animals		
Fire setting		
Defiant		
Unorganized		
Distractible		
Indecisive		
Stealing		
Lying or storytelling		
Wets or soils clothes		
Poor concentration		
Suicidal thinking		

	Past	Current
Difficulty with changes in routine		
Crying		
Sexual behaviors		
Bossy		
Fighting		
Destructive to property		
Accident prone		
Odd noises		
Motor or Vocal Tics		
Negative attitude		
Odd behaviors		
Chewing on things		
Thumb sucking		
Morning problems		
Evening problems		
Difficulty going to sleep		
Restless sleeping		
Nightmares/Night terrors		
Snoring		
Sleep walking		
Sleep talking		
Bed wetting		
Impulsivity		
Self-injurious behavior		

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**SCHOOL**

	Yes	No
Does your child have difficulty paying attention in class?		
Are there problems with your child's grades?		
Has your child ever been recommended for special services?		
Has there ever been a request from the school for mental health or chemical dependency services?		
Has your child ever repeated a grade?		
Does your child have behavior problems in the classroom?		
Does your child have a good relationship with the teacher?		
Does your child have friends at school?		
Does your child complain of health problems to stay home?		
Is your child afraid of going to school?		
Does your child skip school?		

Describe any specific learning problems or learning disabilities identified in your child:

**MEDICAL HISTORY**

Name of child's doctor	Date last treated and reason for treatment
Date of last complete physical	Any abnormal results?
Any physical disabilities or limitations? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain	Is your child up to date on his/her immunizations? <input type="checkbox"/> No <input type="checkbox"/> Yes
When did your child speak his/her first words and sentences, sit up, crawl, walk & complete potty training?	
Child's Height	Child's Weight
Present illnesses for which the child is being treated:	
Has your child received (or receiving) occupational therapy, physical therapy and/or speech therapy? If so, when and who provided it:	

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Please check if any of the following have been a problem in the past or are currently a problem:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne                  | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Rashes/Hives             |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Birth Defect          | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Sinus Problems           |
| <input type="checkbox"/> Bladder Trouble       | <input type="checkbox"/> Growth Problems         | <input type="checkbox"/> Frequent Sore Throats    |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Head Injury             | <input type="checkbox"/> Speech Problems          |
| <input type="checkbox"/> Frequent Chest Colds  | <input type="checkbox"/> Frequent Headaches      | <input type="checkbox"/> Stomach Problems         |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Hearing Problems        | <input type="checkbox"/> Strep Throat             |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Thyroid Illness          |
| <input type="checkbox"/> Frequent Coughing     | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> Vision Problems          |
| <input type="checkbox"/> Dental Problems       | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Vomiting                 |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Lead Poisoning          | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Muscle Aches/Cramps     | <input type="checkbox"/> Persistent Physical Pain |
|  | <input type="checkbox"/> Nose Bleeds             | <input type="checkbox"/> Other _____              |
|  |  | _____   |
|  |  | _____   |

**MISCELLANEOUS**

Please briefly describe your child's and family's religious involvement:
Please describe your child's ethnic and cultural background:
Please describe your child's interests and leisure activities:
Please tell us what your child does well and what things you enjoy about your child:
Please describe any legal problems your child has experienced and what these were and when they occurred. Include the name of the probation officer if applicable.
Does your child have a history of: Physical abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No      Sexual Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No

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Any adverse/allergic reactions to medications?  Yes  No. If yes, please explain:

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Significant Surgeries, hospitalizations, or other medical procedures: (include the month/year that these occurred)

NONE

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Medical diagnoses and conditions: (heart disease, cancer, diabetes, etc...)

NONE

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Please provide the name and dosage of prescription medications your child currently uses (write on back of this page if additional space is needed.)

NONE

Medications child is taking on an on-going basis:	Dosage:	Prescribing Physician:

Please provide the names of all **over-the-counter, herbals, and/or supplements** that your child currently uses:

NONE

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Completed by: \_\_\_\_\_ Reviewed by: \_\_\_\_\_  
Signature Date Clinician Signature Date

**THIS SECTION FOR OFFICE USE ONLY**

Physical Examination Recommended:  Yes  No

Parent/guardian Response to Recommendation:  Yes  No