Family Center By The Falls
Parent Questionnaire

Child's Name:_____ **Today's Date:**_____

Preferred First Name:_____ **Age:**_____ **Grade:** _____

Names of Parents/Guardians:_____

Name of School: _____

Name of Pediatrician:_____

Who referred you to us?_____

Has your child been seen by a different counselor or psychiatrist in the last 90 days? Yes No

If yes, who?_____

What is your main concern about your child at this time?

_____

_____

_____

How does this concern affect your child in terms of:

1. General Behavior:_____

_____

_____

2. Emotional Functioning:_____

_____

_____

3. Relationships:_____

_____

_____

4. Physiological Functioning (i.e. stomach aches, etc.)_____

_____

_____

5. Cognitive (thinking) Functioning:_____

_____

_____

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What made you decide to seek treatment for your child now? What are you hoping to gain?_____

_____

_____

_____

What additional concerns do you have in addition to the main concern?_____

_____

_____

_____

What are your child's assets (strengths, talents, skills, etc.):_____

_____

_____

Current Observations of your child

Please check yes or no	Yes	No	Please check yes or no	Yes	No
Inattention	☐	☐	Panic Attacks	☐	☐
Easily Distracted/Bored	☐	☐	Social anxiety	☐	☐
Messy, disorganized	☐	☐	Performance anxiety	☐	☐
Forgetful	☐	☐	Obsessive Thoughts	☐	☐
Impulsive	☐	☐	Compulsive Behaviors	☐	☐
Accident Prone	☐	☐	Changes in sleep	☐	☐
Impatient	☐	☐	Trouble falling asleep	☐	☐
Risk-taking	☐	☐	Trouble staying asleep	☐	☐
Lazy unmotivated	☐	☐	Waking too early	☐	☐
Trouble completing tasks	☐	☐	Changes in appetite	☐	☐
Needs constant reminders	☐	☐	Weight loss/gain	☐	☐
Fidgety or restless	☐	☐	Change in energy	☐	☐
Hyperactive	☐	☐	Losing interest in things	☐	☐
Cyclical changes in mood	☐	☐	Change in memory/concentration	☐	☐
in speech	☐	☐	Feelings of hopelessness	☐	☐
in sleep	☐	☐	Frequent anger episodes	☐	☐
in irritability	☐	☐	Difficulty with change/transition	☐	☐
in distractibility	☐	☐	Difficulty reading social cues	☐	☐
in impulsivity	☐	☐	Rigid, inflexible thinking	☐	☐
in thinking	☐	☐			
in elevated mood	☐	☐			
in grandiosity	☐	☐			
Mood changes	☐	☐	describe_____		
Thoughts of suicide	☐	☐	describe_____		

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Prior suicide attempts ☐ ☐ **describe**_____
Mood Swings ☐ ☐ **if yes, how long do they last**_____
Hallucinations ☐ ☐ **describe**_____
Paranoid thoughts ☐ ☐ **describe**_____
Odd/inappropriate behavior ☐ ☐ **describe**_____

Over the last month what percentage of time has your child been
sad/unhappy _____ anxious/worried _____ irritable/angry _____

Has your child seen a counselor or psychiatrist before? If yes, who, when and how did your child respond to treatment?

Name of Counselor, Psychologist, Psychiatrist	When seen and for how long?	How did it help

Has your child ever had to leave home to be treated in a psychiatric hospital, residential treatment center, drug rehab, therapeutic school, foster care, etc. or received intensive in-home treatment, MST, partial hospitalization, or Intensive Outpatient services?

Name of Facility and Primary Clinician	When seen and for what purpose	Length and outcome of treatment

<u>Family Psychiatric History</u>

Have any of your child's blood relatives experienced symptoms similar to your child? What do they have in common?_____

_____

_____

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Please list any blood relatives who have been treated for any emotional or behavioral issues, including issues with mood, anxiety, ADHD, postpartum depression, etc. If they received medication please state type and any significant benefits or side effects.

Name of Related Person	How they are related to child	Diagnosis	How they were treated (medicine, counseling)	Response to treatment?

Legal Involvement and Substance Abuse History

Has your child had any incidents that did (or should have) involved the police? If yes, please describe?

_____

Has your child had any court involvement? If yes, name or court and charges:_____

_____

Is your child currently on probation? If yes, please describe why _____

_____

Do you have any reason to believe your child has used the following substance?

Alcohol: Age first used:_____ **Current use (amount and frequency)** _____

Marijuana: Age first used: _____**Current use (amount and frequency)**_____

Tobacco: Age first used: _____ **Current use (amount and frequency)**_____

Other drugs (cocaine, inhalants, stimulants, etc.): Please specify type, amount, and frequency:

_____

_____

_____

_____

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What consequences has your child experienced from substance abuse?_____

_____

_____

Has your child ever had substance abuse assessment or treatment? If yes, please describe where, when, and result?_____

_____

_____

Is there a family history of substance abuse? If yes, please describe who, relationship to child, and substance:

_____

_____

_____

<u>Early Development</u>

Was your child's conception planned or a surprise? _____

Were there any complications during pregnancy? If yes, please describe: _____

_____

_____

Did mom smoke while pregnant? Yes No Drink Alcohol? Yes No Take Medication Yes No

Length of pregnancy (weeks)_____

Type of Delivery: Vaginal or C-section (please state why)_____

Were there any complications that delayed taking your child home?_____

_____

What type of baby was he/she (fussy, colicky, sweet, etc.)?_____

_____

Did your child have any developmental delays (crawling, standing, walking, language)?_____

_____

_____

_____

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How old was your child when they were toilet trained? Were there difficulties with bedwetting, soiling, or daytime wetting?

When did your child sleep first sleep through the night?

Who has taken care of your child? Have there been any major disruptions to care or inconsistency in caretaking?

Has your child ever been a victim of emotional, sexual, or physical abuse? If yes, please describe.

How has/does your child respond to changes in their routine?

School

What was his/her adjustment to school like? How are his/her mornings before school? How are his/her afternoons after school?

How does he/she get along with classmates? Teachers?

Has your child ever been suspended, expelled or received detention? If yes, please describe:

How is your child's attendance?

What is your child's academic performance like? Have there been changes in the past year?

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Are there factors that compromise his/her academic functioning?_____

_____

_____

Was your child every held back? If yes, what grade and why?_____

_____

Has your child been identified as having a learning disability? If yes, by whom and what type of disability?_____

_____

_____

Is your child in any support classes or special education? If yes, describe?_____

_____

Has your child had a multi-factored evaluation? If yes, when (please bring a copy)_____

Does your child have an IEP or 504 plan? Yes No If yes, please bring a copy

Does your child's school have a good idea about how to meet your child's needs? Please describe?____

_____

Is homework completion a problem? Yes No If so how often?_____

Does your child forget to:

Turn in work? Yes No If so how often?_____

Write down assignments? Yes No

Bring books home for homework? Yes NO

Does your child:

Make careless mistakes? Yes No

Procrastinate on work? Yes No

Need lots of supervision to do work? Yes No

Take too long on work? Yes NO

Does your child have any particular career goals or other future goals?_____

_____

_____

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Please bring (if applicable) copies of your child's report cards, multi-factored evaluations/ETR, IEP, 504 Plan, cognitive testing (Iowa Test, SCOGAT, Stanford Tests, Entrance Exams, etc.) to your child's initial appointment.

Peers

What are your child's favorite activities and interests?_____

_____

Is your child involved in any sports, clubs, or other extracurricular activities?_____

_____

What are your child's friends like?_____

_____

_____

How long do your child's friendships last?_____

_____

Is it hard for your child to make/keep friends? If yes, describe why:_____

_____

_____

Has your child been involved in dating relationships? Please describe:_____

_____

_____

Is your child sexually active? Yes No Don't Know

Does your child have any concerns about: Sexual Orientation: Yes No Gender Identity: Yes No

Medical History

Complete the italics if patient is female

Last menstrual cycle: _____ ***Using birth control? Yes No***

Premenstrual mood changes:_____

How would you describe your child's eating patterns?_____

Any changes in appetite? Yes No Weight changes? Yes No Energy Level changes? Yes No

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Does your child have any medical conditions at this time? If yes, please describe and tell how it impacts your child psychologically?_____

_____

_____

Has your child ever been hospitalized? If yes, describe when and why:_____

_____

_____

Has your child had surgery? If yes, describe when and why:_____

_____

Does your child have a preoccupation with fire, matches? Yes No

Does your child have a history of Animal cruelty? Yes No

Is there a family history of:

Structural heart disease (explain):_____

Sudden death before age 50 (explain):_____

Check all that apply:

_____Heart murmur	**_____Head injury**	**_____Diabetes**
_____Arrhythmia	**_____Headaches**	**_____Thyroid problems**
_____Structural heart disease	**_____Tremor**	**_____Skin**
_____Hypertension	**_____Genetic Abnormalities**	**_____Asthma**
_____Tachycardia	**_____Nausea**	**_____Allergies**
_____Chest pain	**_____Vomiting**	**_____Infections**
_____Seizures/Epilepsy	**_____Abdominal pain**	**_____Urinary problems**
_____Vocal or motor tics	**_____Anorexia**	

Medication Allergies? Please list:_____

Please list medications (<u>not for behavioral/mental health issues</u>) your child takes (dose, times administered)

_____

_____

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Please list "over the counter" medications, supplements or natural remedies your child takes (does, times)

Please list every medication your child is taking or has taken <u>for behavioral/mental health issues</u>, in order, from first to most recent:

Medication	Dose and time taken	Doctor who prescribed	Why was it prescribed?	Dates taken	What did it do?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Any additional comments about medication:

If your child has never been treated with medication, what fears or concerns would you (or other family members have) if one of our physicians recommended medication?

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Family Relationships and Activities

Parents: Married Separated Divorced

Name, Age, Occupation_____

Name, Age, Occupation_____

If divorced, what are the custody arrangements:_____

_____

Step-parents if applicable:

Step-mom_____

Step-dad_____

Who else lives in the home (other relatives, friends, siblings)?

Name, Age, Relationship_____

Name, Age, Relationship_____

Name, Age, Relationship_____

Name, Age, Relationship_____

Name, Age, Relationship_____

What is the relationship like between parents or major caregivers?_____

_____

_____

Has your child ever witnessed domestic violence? If yes, describe:_____

_____

What is your child's relationship like with each parent or caregiver?_____

_____

_____

How do you discipline your child? Is it working? Do the parents agree on discipline and have the same style of parenting?_____

_____

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How do you promote good behavior?

What is the household climate like? Conflictual? Warm? Permissive?

How is your child's behavior with each sibling?

How does your child's family relationships differ from his/her relationships with others?

Please describe your family activities (ie. Travel, board games, etc.)

Is your family involved in a church or a place of worship? If yes, where and what is your child's involvement?

How does your faith impact your child and how you live your life?

What are your family connections in terms of support or significant others in your child's life?

Is there anything else about your family that is important for us to know?

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Is there any other important information you would like for us to know about your child or your family?

Name of Person Completing Form **Relationship to Child**