

**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	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>
Easily Distracted/Bored	<input type="checkbox"/>	<input type="checkbox"/>	Social anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Messy, disorganized	<input type="checkbox"/>	<input type="checkbox"/>	Performance anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Forgetful	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
Accident Prone	<input type="checkbox"/>	<input type="checkbox"/>	Changes in sleep	<input type="checkbox"/>	<input type="checkbox"/>
Impatient	<input type="checkbox"/>	<input type="checkbox"/>	Trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>
Risk-taking	<input type="checkbox"/>	<input type="checkbox"/>	Trouble staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
Lazy unmotivated	<input type="checkbox"/>	<input type="checkbox"/>	Waking too early	<input type="checkbox"/>	<input type="checkbox"/>
Trouble completing tasks	<input type="checkbox"/>	<input type="checkbox"/>	Changes in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Needs constant reminders	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
Fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Change in energy	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	Losing interest in things	<input type="checkbox"/>	<input type="checkbox"/>
Cyclical changes in mood	<input type="checkbox"/>	<input type="checkbox"/>	Change in memory/concentration	<input type="checkbox"/>	<input type="checkbox"/>
in speech	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness	<input type="checkbox"/>	<input type="checkbox"/>
in sleep	<input type="checkbox"/>	<input type="checkbox"/>	Frequent anger episodes	<input type="checkbox"/>	<input type="checkbox"/>
in irritability	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with change/transition	<input type="checkbox"/>	<input type="checkbox"/>
in distractibility	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty reading social cues	<input type="checkbox"/>	<input type="checkbox"/>
in impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	Rigid, inflexible thinking	<input type="checkbox"/>	<input type="checkbox"/>
in thinking	<input type="checkbox"/>	<input type="checkbox"/>			
in elevated mood	<input type="checkbox"/>	<input type="checkbox"/>			
in grandiosity	<input type="checkbox"/>	<input type="checkbox"/>			
Mood changes	<input type="checkbox"/>	<input type="checkbox"/>	describe _____		
Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	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

Family Psychiatric History

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:

Early Development

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 (not for behavioral/mental health issues) 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 for behavioral/mental health issues, 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