CenterLife Counseling

Centerville Clinic
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White Bear Lake Clinic
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Phone: 651-289-3111 Fax: 651-289-3113

Date: _____

Parent Questionnaire

All information on this form is considered strictly confidential within the guidelines of the clinic.

Child's Name _____ **DOB** _____ **Age** _____

Your Name _____ **Relationship to Client** _____

How did you hear about us? Insurance Friend/Family Web/Social Media Newspaper Other _____

Please describe the reason for this visit to our clinic: _____

_____

How distressing is this issue for the child? *(on a scale of 1-10, with 1=not distressing, 10=most distressing)*: _____

Please indicate how this has affected the child's ability to function:

In Daily Life	Not at all	Minimally	Moderately	Significantly/Severely
Academically	Not at all	Minimally	Moderately	Significantly/Severely
Within the Family	Not at all	Minimally	Moderately	Significantly/Severely
Interpersonally/Socially	Not at all	Minimally	Moderately	Significantly/Severely

How long has the child been experiencing distress about this issue?_____

What resources do you feel the child has to help them work through this issue? _____

_____

Symptoms and Issues You Have Observed

_____ Anxious, worried
_____ Anger, aggression, or violence
_____ Attitude issues
_____ Bored
_____ Bullying: By others To others
_____ Confused
_____ Cutting, burning, or hurting of self
_____ Counting or ordering of things
_____ Concentration or focus issues
_____ Conflicts with adults (parents, teachers, etc)
_____ Conflicts with others (friends, other kids)
_____ Crying or tearful
_____ Depressed mood
_____ Difficulty being alone
_____ Disorganized
_____ Drug or alcohol issues
_____ Easily distracted
_____ Easily irritated
_____ Fatigued or tired often
_____ Fears (monsters, snakes, people, etc.)
_____ Guilt feelings/shame
_____ Hyperactive
_____ Impulsive
_____ Legal issues
_____ Living arrangement issues
_____ Lying frequently
_____ Lonely
_____ Money issues
_____ Mood swings
_____ Motivation reduced or absent
_____ Overly worried about germs, organization
_____ Panic attacks
_____ Perfectionism
_____ Physical problems (stomach, headache)
_____ Self-esteem low
_____ Sexual identity concerns
_____ Sexual issues
_____ School or employment issues
_____ Shy or uneasy around others
_____ Unassertive
_____ Unwanted behaviors or thoughts
_____ Withdrawn or alone too much

Symptoms and Issues *(continued)*

_____ Energy levels
__ Too much energy (beyond what is developmentally appropriate)
__ Too little energy

_____ Sleep problems
__ Trouble falling asleep
__ Trouble staying asleep
__ Trouble sleeping too much/too little

_____ Eating habits
__ Binging (eating much more than is needed, or is normal, in a specific time period)
__ Purging (making self vomit after eating)
__ Restricting (not eating enough or not eating at all)
__ Overeating (consistently, over time)
__ Using laxatives to control weight

_____ Weight changes
__ Increase Please describe: _____
__ Decrease Please describe: _____

_____ Behavior problems
__ At Home
__ At School/After school
__ At Work
__ With friends/In social settings

Background Information *(Please provide information for the person who is being seen.)*

Biological/Adoptive Parents:

Name Age Education Occupation

_____

_____

Dates of marriage and/or divorce for biological/adoptive parents: _____

If the child is adopted or a foster placement, please answer the following:

If a kinship or relative adoption, what is your relationship to the child? _____

When did the child join your family? _____

What were the circumstances of the adoption/placement? _____

_____

_____

If the placement is temporary, when is the child expected to return home? _____

Does the child have contact with his/her biological parents? Y N

If yes, please explain: _____

If the child was adopted from another country, please list the country of origin. _____

Please describe any details about the situation the child was in prior to adoption. _____

_____

_____

Siblings: *Indicate if A (adoptive), H (half), or S (step)*

Name Age Grade/Education Physical/Emotional Health History

_____

_____

_____

If the child's biological/adoptive parents are not together, please complete the following information for step-parents/partners.

Name of Parent Name of Step-Parent/Partner Age Occupation

Custody and Visitation Arrangements:

Are there any current legal proceedings related to custody involving the child? Y N

If yes, please describe: _____

Currently live in: Single Family Home Apartment/Condo Townhouse/Condo Mobil Home Other: _____

List any others living in the home and the circumstances (ex: grandparents or step-siblings that may live in the home for part of the week).

Name Age Relationship to Child Circumstance

Has the child ever been placed outside the home (shelter, foster home, or group home)? Y N

If yes, please provide details: _____

Has the child ever been arrested or placed on probation? Y N

If yes, please provide details: _____

Safety

Does the child have a history of abuse or trauma? _____ Not Applicable

Physical Y N
If yes, when and please describe: _____
Sexual Y N
If yes, when and please describe: _____
Emotional Y N
If yes, when and please describe: _____
Verbal Y N
If yes, when and please describe: _____
Neglect Y N
If yes, when and please describe: _____
Domestic Abuse
If yes, when and please describe: _____
Other
If yes, when and please describe: _____

Has the child ever experienced:

Suicidal Thoughts Y N
If yes, when and please describe: _____
Suicide Attempts Y N
If yes, when and please describe: _____
Self-harm Y N
If yes, when and please describe: _____

Is the child involved in any legal proceedings related to the safety issues listed above? Y N

If yes, please describe: _____

_____

Are there any current or past child protection issues? Y N

If yes, please describe: _____

_____

History of Problem

When and how did you first notice the problem? _____

_____

_____

_____

What kinds of changes have you seen in the child (such as changes in academics, sleep, or eating patterns)? _____

_____

_____

_____

Please describe any changes or incidents (such as moving, a death in the family, change of schools, birth of a sibling, death of a pet, financial/legal problems, etc.) which seem to have affected the child. _____

_____

_____

_____

What was the child's reaction to the above changes or incidents? _____

_____

_____

How have you tried to resolve the problem? Please list things that ***have*** worked as well as things that ***have not*** worked.

_____

_____

_____

Family Interaction

What do you do together as a family? _____

_____

_____

How does your family express feelings? _____

How often are there conflicts in your family? _____

What are the conflicts typically about? _____

How are these conflicts resolved? _____

Who is typically in charge of discipline in your family? _____

What type of discipline is used in your family? _____

Family History

What is your family cultural background (ethnic or racial origin)? _____

What is your family religious background? _____

Please list any cultural or religious traditions that are important in your family. _____

Please list any medical history (such as diabetes, cancer, hearing/vision problems, sensory integration disorder, etc.) for family members (include cousins, aunts/uncles, grandparents, etc.).

Name	Relationship to Child	Medical Issue

Please list any mental health history (such as ADHD, Autism, Anxiety, Learning Disabilities, Bipolar Disorder, etc.) for family members (include cousins, aunts/uncles, grandparents, etc.).

Name	Relationship to Child	Mental Health Issue

Please list any substance use history (such as alcoholism or drug addiction) in your immediate or extended family (include cousins, aunts/uncles, grandparents, etc.).

Name	Relationship to Child	Substance Use Issue

Developmental History Please provide the following information. If the child is adopted or a foster placement, provide as much information as possible.

Was the child full term? Y N If no, please explain: _____

_____

The child was born: C-section Vaginal Induced Early/Premature

How did you react to news of the pregnancy? _____

Were there any complications during the pregnancy or birth? Y N If yes, please provide details:

_____

What approximate age did the child develop in:

Speech Single words _____ Simple sentences _____ Complete sentences _____

Mobility Crawl _____ Walk _____ Run _____

Toilet Training Bladder trained _____ Bowel trained _____

Please list any problems with toilet training. _____

Please list any problems with toilet training after the child had mastered it. _____

_____

Please describe any emotional or behavioral difficulties:

As an infant: _____

As a toddler: _____

As a preschooler: _____

During elementary school: _____

During middle school: _____

During high school: _____

Are/were normal separations tolerated before school age? Y N If no, please describe: _____

_____

Please describe any developmental eating problems. _____

_____

Please describe any developmental sleeping problems. _____

_____

Educational History

What school/daycare/preschool is the child currently enrolled in? _____

At what age did the child begin school? _____ What grade is the child currently in? _____

Has the child repeated or skipped any grades? Y N If yes, please explain: _____

What kinds of grades does the child typically receive? _____

Have there been any changes to academic performance? Y N

If yes, please describe: _____

What are the child's favorite subjects? _____

What are the child's least favorite subjects? _____

Did the child receive a 3-year-old assessment from the school district? Y N

If yes, what were the outcomes? _____

Does the child receive any support services (such as Special Education, IEP, 504 plan, Title 1)? Y N

If yes, please describe: _____

Has the child been assessed for any learning disabilities (LD, EBD, Non-verbal learning disorder)? Y N

If yes, please describe: _____

Have there been any academic, behavioral, or emotional problems with peers or teachers? Y N

If yes, please describe: _____

Has the child ever been given detention, suspended, or expelled from school? Y N

If yes, please describe: _____

Psychological/Mental Health History

Has the child received services from the school counselor/psychologist/social worker? Y N

If yes, please describe: _____

_____

Current or Previous Counseling/Therapy

Clinic or Therapist	Dates of Services	Reason/Diagnosis

Psychiatric Hospitalizations/Partial Hospital Program/Intensive Outpatient Program

Hospital/Clinic	Dates of Services	Reason/Diagnosis

Medical History

Primary Care Physician _____ Clinic _____

Date of last visit and outcome(s): _____

Psychiatrist _____ Clinic _____

Date of last visit and outcome(s): _____

Medical Concerns in the previous year: _____

_____

Has the child ever received OT (Occupational Therapy), PT (Physical Therapy), or Speech Therapy? Y N

If yes, please explain: _____

Has the child ever received social security income? Y N If yes, please explain: _____

_____

Medications:

Name of Medication and Dosage	**Purpose**	**Length of Use**

Does the child have a history of:

Head Injury	Y	N	If yes, describe: _____
Concussion	Y	N	If yes, describe: _____
Car Accident	Y	N	If yes, describe: _____
Surgeries	Y	N	If yes, describe: _____
Chronic Illness	Y	N	If yes, describe: _____
Seizures	Y	N	If yes, describe: _____
Allergies	Y	N	If yes, describe: _____
Disabilities	Y	N	If yes, describe: _____

Has the child ever been injured while playing any sports (football, hockey, soccer, skiing, cheerleading, etc.)? Y N
If yes, please describe: _____

Social History

How many close friends does the child have at this time? _____ Frequency of contact _____

If the child has been worried about friends' actions/behaviors, please describe. _____

_____

Recreation, hobbies, interests: _____

Organized activities/sports (such as Girl/Boy Scouts, community baseball, gymnastics, YMCA): _____

_____

What do you feel the child does well? _____

_____

Employment History

Does the child have a job, either in school or outside school? Y N Typical Hours: _____

Current Employer/Job Position: _____

Previous Employment:

Position Duties Dates (from-to)

_____

_____

_____

Substance Use

Please identify the child's current and historic substance use:

Substance	Type	Quantity	Frequency	Dates of Use (from-to)
Alcohol				
Tobacco				
Illicit Drugs				
Misuse of Rx meds				
Other				

Please describe the child's consumption of caffeine (coffee, soda, energy drinks, etc.). _____

_____

Has the child experienced any undesirable results (DUI, DWI, school failure, etc.) from substance use? Y N

If yes, please describe: _____

Has the child attended (past or present) a self-help group, such as AA, NA, or Alateen? Y N

If yes, please describe: _____

CD Treatment History:

Name of Program/Provider	Inpatient/Outpatient	Dates (from-to)

Client Expectations

How do you feel about seeking help for the child at this time? _____

What goals do you have for therapy for the child? _____

What research have you done related to the reason for this visit? _____

How long do you expect the child to continue therapy? _____

How often would you like the child to attend therapy? _____

What else do we need to know that we have not asked? _____