CenterLife Counseling

Centerville Clinic
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Phone: 651-288-0332 Fax: 651-288-0493

White Bear Lake Clinic
4444 Centerville Rd. Suite 235, White Bear Lake, MN 55127
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 *(Check all that apply)*

_____ 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: ☐ N/A

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)* ☐ N/A

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. ☐ N/A

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

Custody and Visitation Arrangements: ☐ N/A

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). ☐ N/A

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?

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 Y N
If yes, when and please describe: _____
Other Y N
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 ☐ N/A

Clinic or Therapist	Dates of Services	Reason/Diagnosis

Psychiatric Hospitalizations/Partial Hospital Program/Intensive Outpatient Program ☐ N/A

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: ☐ N/A

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 ☐ N/A

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 ☐ N/A

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: ☐ N/A

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? _____