PARENT/LEGAL GUARDIAN QUESTIONNAIRE/PSYCHOSOCIAL

Child and Adolescent Assessment for Ages 15 and Younger

Name of Child/Adolescent: _____ Age: _____ DOB: _____

Sex: ❒ M ❒ F Grade: _____ School: _____ Ethnicity/Race: _____

What event(s) or problems have caused you to come for treatment? _____

_____

_____

_____

PAST TREATMENT

Has your child ever had any previous mental health treatment? ❒ Yes ❒ No

If so, check which type(s) and the date/age at time of treatment:

- ❒ Psychological Testing: _____
- ❒ Individual/Group/Family Therapy: _____
- ❒ Psychiatric Hospitalization: _____
- ❒ Residential Treatment: _____

What was the diagnosis? _____

Is your child currently on any medications? ❒ Yes ❒ No

List: _____

_____

What medications has your child taken in the past for anxiety, depression, ADHD, etc?

List: _____

_____

_____

Do you think any of these medications, past or present, have been effective? ❒ Yes ❒ No

Please explain: _____

_____

_____

_____

SYMPTOMS Please check any that apply presently or in the past.

❒ Sleep Problems	❒ Anger Problems	❒ Behavior Problems at School
❒ Nightmares	❒ Mood Swings	❒ Academic Problems
❒ Low Energy	❒ Temper Tantrums	❒ Talk/Thoughts of Death
❒ Concentration Problems	❒ Depressed Mood	❒ Hurt Self or Others
❒ Appetite Problems	❒ Anxiety/Worry/Panic	❒ Harm to Animals
❒ Bingeing/Purging	❒ Obsession/Compulsions	❒ Alcohol/Drug/Tobacco Use
❒ Health Complaints (e.g., headaches, stomach aches)	❒ Fears	❒ Sexual Acting Out
	❒ Oppositional/Defiant	❒ Runaway

MEDICAL HISTORY

Please rate your child/adolescent in each of the following areas:

	Good	Fair	Poor
Health			
Hearing			
Vision			
Gross Motor Coordination			
Fine Motor Coordination			
Speech Articulation			

Did your child/adolescent experience prenatal exposure to alcohol, tobacco or drugs? ❒ Yes ❒ No

Has your child/adolescent's physical development been normal? ❒ Yes ❒ No

If no, please explain: _____

Has your child/adolescent had any chronic health problems (e.g. asthma, diabetes, heart condition)? ❒ Yes ❒ No

If yes, please explain: _____

Are immunizations current and up to date? ❒ Yes ❒ No

Check which of the following illnesses your child/adolescent has had:

❒ Mumps ❒ Chicken Pox ❒ Measles ❒ Whooping Cough ❒ Scarlet Fever ❒ Pneumonia ❒ Seizures
❒ Encephalitis ❒ Otitis Media ❒ Lead Poisoning ❒ Other _____

How many accidents has your child/adolescent had? ❒ One ❒ 2-3 ❒ 4-7 ❒ 8-12 ❒ over 12

Check if your child/adolescent has had any accidents resulting in the following:

❒ Broken Bones ❒ Head Injury ❒ Stomach Pumped ❒ Lost Teeth ❒ Eye Injury ❒ Severe Lacerations
❒ Stitches ❒ Severe Bruises ❒ Other _____

Check if your child/adolescent has had surgery for any of the following conditions:

❒ Tonsillitis ❒ Appendicitis ❒ Leg Or Arm ❒ Burns ❒ Adenoids ❒ Digestive Disorder ❒ Hernia
❒ Eye, Ear, Nose or Throat ❒ Urinary Tract ❒ Other _____

Does your child/adolescent have bladder control problems?

At night? ❒ Yes ❒ No If yes, how often? _____

During the day? ❒ Yes ❒ No If yes, how often? _____

Does your child/adolescent have bowel control problems?

At night? ❒ Yes ❒ No If yes, how often? _____

During the day? ❒ Yes ❒ No If yes, how often? _____

Has your child/adolescent ever been diagnosed with a medical problem? ❒ Yes ❒ No

If yes, what and how treated? _____

_____

_____

_____

_____

What are your child/adolescent's current medical needs? _____

_____

_____

_____

_____

_____

_____

SEXUAL MATURATION HISTORY

At what age did your child/adolescent show adult body development? _____

At what age did your daughter begin menstruating? _____

Were there any special problems with the onset of menstruation/body development? ❒ Yes ❒ No

Does your child/adolescent appear appropriately comfortable with the opposite sex? ❒ Yes ❒ No

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

Have there been any pregnancies or abortions? ❒ Yes ❒ No ❒ Don't Know

Has your child/adolescent ever been the recipient of or perpetrator of neglect, violence, or sexual abuse? ❒ Yes ❒ No

If yes, please explain: _____

_____

_____

Additional Comments: _____

_____

_____

SCHOOL HISTORY

Indicate any of the following school problems that apply.

	During what grade(s)?
Oppositional	
Disrupt class	
Inattentive	
Refuse to go to school	
Fail to turn in work	
Disorganized	
In-school suspension	
Out-of-school suspension	
Expelled from School	

Has your child/adolescent ever had problems with his or her learning ability? ❒ Yes ❒ No

If yes, please explain: _____

_____

Summarize your child/adolescent's progress (e.g. grades, academic, social, behavioral) within each of the following grade levels. Also list whether your child/adolescent attended public, private or home school.

Preschool: _____

Kindergarten: _____

Grades 1-3: _____

Grades 4-6: _____

Middle School/Junior High: _____

High School: _____

Have instructional modifications been attempted? ❒ Yes ❒ No

If yes, please list: _____

_____

Has your child/adolescent had any educational testing? ❒ Yes ❒ No

If yes, please list: _____

_____

What is your child's learning style? _____

SOCIAL HISTORY

How does your child/adolescent get along with his/her brothers/sisters?

❒ Better than average ❒ Average ❒ Worse than average ❒ Doesn't have any siblings

How easily does your child/adolescent make friends?

❒ Easier than average ❒ Average ❒ Worse than average

About how many close friends does your child/adolescent have?

❒ None ❒ 1 ❒ 2 or 3 ❒ 4 or more

On the average, how long does your child/adolescent keep friendships?

❒ Less than 6 months ❒ 6 months – 1 year ❒ 2 years or more

Describe your child socially:

❒ Withdrawn ❒ Insecure ❒ Outgoing ❒ Passive ❒ Aggressive ❒ Other _____

What extracurricular activities is your child/adolescent involved in? _____

_____

What jobs or chores does your child/adolescent have? _____

_____

Has your child/adolescent ever had any legal problems? ❒ Yes ❒ No

If yes, please explain: _____

_____

Are you aware of any alcohol, tobacco, and/or other drug use by your child/adolescent? ❒ Yes ❒ No

If yes, please explain: _____

_____

RELIGIOUS/FAITH HISTORY

What is your family's religious background? _____

Does your child/adolescent currently attend religious services? ❒ Yes ❒ No

If yes, where? _____

Please list any issues (positive or negative) that are important or may have affected your child in regard to faith:

_____

_____

_____

_____

FAMILY HISTORY

Check if there is any history of the following in the family. If yes, write in who (e.g., mother, grandfather, aunt, etc.)

	Who		Who
Learning Disabilities		Physical or Sexual Abuse	
ADD/ADHD		Psychosis or Schizophrenia	
Mental Retardation		Tics or Tourettes	
Depression		Bipolar Disorder (Manic Depression)	
Anxiety Disorder		Birth Defects	
Alcohol or Drug Abuse		Diabetes	
Arrests		Suicide Attempts/Suicide	

Who has legal custody of your child/adolescent? _____

Current living situation of child/adolescent:

❒ Both parents' home ❒ Relative's Home

❒ One parent's home ❒ Friend's Home

❒ Legal guardian's home ❒ Other _____

Primary living situation for past year:

❒ Both parent's home ❒ Relative's Home

❒ One parent's home ❒ Friend's Home

❒ Legal guardian's home ❒ Other _____

Please describe the family home: ❒ House ❒ Apartment ❒ Condo Other _____

Number of rooms _____ Number of bathrooms _____ Number of bedrooms _____

Please indicate who sleeps in each bedroom: _____

_____

Please describe your neighborhood: _____

_____

Who has taken care of your child/adolescent most of their life? _____

_____

Who is the primary disciplinarian in the family? _____

Are they: ❒ Strict ❒ Lenient

Do parents agree on the issues of parenting, rules and discipline? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely

What strategies have been used to address problems? (Check those that apply and circle those that have been successful):

❒ Verbal Reprimands ❒ Time Out ❒ Removal of Privileges ❒ Rewards

❒ Physical Punishment ❒ Giving In To your child ❒ Avoiding your child

On the average, what percentage of time does your child/adolescent comply with initial commands?

❒ 0-20% ❒ 21-40% ❒ 41-60% ❒ 61-80% ❒ 81-100%

On the average, what percentage of the time does your child/adolescent eventually comply with commands?

❒ 0-20% ❒ 21-40% ❒ 41-60% ❒ 61-80% ❒ 81-100%

Do parents get along with one another? ❒ Always ❒ Usually ❒ Sometimes ❒ Rarely

Have there been or are there currently any major changes or stresses in the family where your child was raised?

❒ Yes ❒ No If yes, please check all the following that apply:

	In past	Current (6 months or less)
Financial problems		
Frequent moves		
Job changes		
Drinking and/or drug problems		
Arguments between parents/partners		
Separation or divorce of parents		
Remarriage of parent(s)		
Separation from sibling(s)		
Frequent physical punishment		
Physical confrontations between parents/partners		
Mental illness in family		
Physical illness in family		
Psychiatric hospitalization of a parent/partner		
Death in the family		
Incestuous behavior in family		
Other: Explain		

What are the family's strengths? _____

_____

_____

What are the family's weaknesses? _____

_____

_____

What are your child/adolescent's strengths? _____

_____

_____

What are your child/adolescent's weaknesses? _____

_____

_____

What do you see as an issue(s) important to your child/adolescent? _____

_____

_____

Please mark any of the statements below that apply to your family:

	Yes	No
Our family is warm and loving.		
People are often arguing in our family.		
Everyone goes his or her own separate way.		
Family members say what is on their minds.		
Our family hides things.		

What would you like to change about your family? _____

_____

_____

_____

_____

How has the family been changed by your child/adolescent's problem(s)? _____

_____

_____

_____

_____

What is the family's expectation of treatment? _____

_____

_____

_____

_____

What does the family see as their role in treatment? Which family members are willing and able to participate?

_____

_____

_____

_____

_____

List any disabilities or disorders that your child/adolescent has that were not previously mentioned?

_____

_____

_____

_____

Describe your child/adolescent's adjustment to these disabilities and/or disorders. _____

_____

_____

_____

_____

Is there a need for assistive technology in the treatment of your child/adolescent? ❒ Yes ❒ No

If yes, what is that need? _____

_____

_____

_____

Is there anything else about your child/adolescent or family that we should know in order to be more helpful?

_____

_____

_____

_____

_____

_____

_____

Note: Bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment.

_____ _____

(Parent/Legal Guardian Signature) (Date)

Read and Reviewed by _____ _____

(Clinician) (Date)