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INITIAL QUESTIONNAIRE FOR PARENTS/GUARDIANS

Client Information

Client Name:_____ Nickname or Preferred Name: _____

Age: _____ Date of Birth: _____ Race: _____

Client Cell Phone: _____ Languages: _____

Home Phone: _____ Client E-mail: _____

Home Address: _____

Person Completing Form: _____ Relation to Child: _____

Who is primary contact parent? _____

Parent Information

Parent 1:_____ Age: _____ Date of Birth _____

Home Phone: _____ ok to leave message? Yes No

Cell Phone: _____ ok to leave message? Yes No

Email Address: _____ ok to leave message? Yes No

Address if different from client: _____

Occupation: _____ Education Completed: _____

Parent 2:_____ Age: _____ Date of Birth _____

Home Phone: _____ ok to leave message? Yes No

Cell Phone: _____ ok to leave message? Yes No

Email Address: _____ ok to leave message? Yes No

Address if different from client: _____

Occupation: _____ Education Completed: _____

Parent's marital status: ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed
☐ Single ☐ Cohabitants

If married, how long have you been married? _____

If divorced, how long have you been divorced? _____ Age of client at divorce? _____

Current custody arrangement. **Please provide a copy of custody agreement**: _____

_____

Step-parent information (if applicable – name, cell phone, age, occupation): _____

_____

Additional Family Members and Other People Living in the Home:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

In Case of Emergency, Please Call:

Name: _____ Relationship: _____ Phone#:_____

Name: _____ Relationship: _____ Phone#:_____

How were you referred? _____

Why You're Here:

1. Describe the main reasons you are seeking assistance: _____

   _____

   _____

   _____

   _____

   _____

   _____

2. How have you been dealing with these issues so far?: _____

   _____

   _____

3. How do you hope I can be of help?: _____

   _____

   _____

4. What do you think is a realistic time frame for solving your problem?_____
5. Do you have any concerns or fears about your teen participating in therapy? _____

   _____

Client Symptoms and Behaviors:

Does your teen have any past/current substance use/abuse? ☐ cigarettes ☐drugs

☐ alcohol ☐ denies use ☐ suspected, but unknown ☐ remission 90+ days ☐ none

If yes, please describe substances used, amount, and effect on child's performance at home and school: _____

_____

Please indicate how each of the following symptoms/problems/complaints affects your teen. Enter (0) for none, (1) mild, (2) moderate, or (3) severe. Add comments as desired.

	Accident-prone		Aggression toward others
	Angry outbursts		Appetite increase/decrease
	Argues/talks back		Binging/purging
	Body image issues		Bossy to others
	Breaks the law		Bullied by others
	Bullies/intimidates		Cheats
	Child abuse		Complains often
	Cries easily		Cruel to animals
	Destructive		Developmental delays
	Difficulties w/parent's relationship/new marriage		Difficulty concentrating
	Disobedient/defiant		Domestic violence
	Dramatic emotional highs and/or lows		Fatigue/decrease in energy
	Fearful/worries		Feelings are easily hurt
	Feelings of guilt, worthlessness		Feelings of not belonging
	Fighting		Fire setting/plays with fire
	Frequent stomachaches/headaches		Gang involvement
	Generalized anxiety		Grades dropping or consistently low
	Hearing voices		Hopelessness
	Hyperactive		Immature
	Inappropriate sexual behaviors		Inattentive/distractible
	Intrusive thoughts, repetitive behaviors		Irritable
	Isolates/withdraws		Lacks organization
	Lacks respect for authority		Learning disability
	Lethargic		Loss of interest in usual activities
	Low frustration tolerance		Lying
	Manipulates		Moody
	Mute/refuses to speak		Nail biting/hair chewing
	Need for high degree of supervision		Nervous
	Nightmares		Oppositional
	Overeats		Over exercising
	Panic attacks		Poor sibling or friend relationships
	Poor social skills		Problems falling/staying asleep
	Procrastinates		Provokes others
	Recent move/new school/loss of friends		Recent losses
	Restless/fidgety		Rocking/repetitive movements
	Runs away		Sad/unhappy
	School avoidance		Sees things that aren't there
	Self-harming behaviors/cutting		Sells drugs
	Separation anxiety		Sexual preoccupation
	Sexual identity issues		Shy/timid
	Speech difficulties		Steals
	Stubborn		Suicidal thoughts
	Suicide attempt(s)		Swearing
	Teased/picked on		Tics
	Trauma history		Truancy
	Weight Change		Wetting/soiling bed/clothes

Client's School History:

Current School District: _____ Grade: _____

School Name: _____ Phone #: _____

Review history of school functioning including strengths: (Gifted or accelerated learning program, learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement):_____

_____

Has your teen been evaluated for developmental, behavioral, or learning problems? ☐ Yes ☐ No

If so, why, what kind, by whom, and what were you told about the results? _____

_____

_____

Is there a current IEP? ☐ Yes ☐ No **If yes, please provide a copy**.

Teen is designated: ☐ Emotionally Disturbed (ED) ☐ Specific Learning Disability (SLD)

☐ Other _____

What school interventions have been used to address problems?: _____

_____

Has the teen been suspended/expelled in past 12 months? If yes, how many times and the reasons:

_____

Client's Health:

1. Starting with birth and proceeding up to the present, list all allergies, diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has had: _____

   _____

   _____

   _____

   _____

   _____

   _____

2. Has your teen ever had any previous psychotherapy or psychiatric treatment? If so, why, where, how long, and did you feel it was helpful?: _____

_____

_____

_____

Physician Name and Number: _____ Date of Last Visit: _____

Psychiatrist Name and Number: _____ Date of Last Visit: _____

All Prescribed Medications	Purpose	Dose	Side Effects

Family Mental Health History:

In the section below identify if there is a family member who is currently or in the past has experienced any of the following.

	Circle	Circle	List Family Member
Alcohol/Substance Abuse	Yes/No	Past/Current	_____
Anxiety	Yes/No	Past/Current	_____
Depression	Yes/No	Past/Current	_____
Suicide Attempts	Yes/No	Past/Current	_____
Domestic Violence	Yes/No	Past/Current	_____
Child Abuse	Yes/No	Past/Current	_____
Eating Disorders	Yes/No	Past/Current	_____
Obesity	Yes/No	Past/Current	_____
Schizophrenia	Yes/No	Past/Current	_____
Other (please describe)	_____		

Additional Family Information

1. Stress in your life

	Please Circle	Describe
Financial difficulties	Yes/No	_____
Health problems	Yes/No	_____
Family/relationship difficulties	Yes/No	_____
Job/Work stress	Yes/No	_____

2. Describe significant events in your family life that may have had an impact on your teen (i.e. major moves, changes in school, divorce, loss of a loved one, abuse and/or assault of any kind, legal troubles): _____

_____

3. Is Alcohol consumed by family members? ☐ Yes ☐ No If yes, what kind, how much, how often, by whom?_____

_____

4. Are recreational drugs used by family members? ☐ Yes ☐ No If yes, what kind, how much, how often, by whom?_____

_____

5. How is conflict resolved in the family? _____

_____

6. How do you set limits with your teen? _____

_____

7. How would you describe your co-parenting relationship? _____

_____

8. Does your family eat dinner together? Yes/No How many nights a week? _____
9. What other activities does your family enjoy doing together? _____

_____

How often? _____

10. How would you describe your relationship with your teenager? _____

_____

11. How would you rate your overall level of happiness on a scale of 1-5? (1 = UNHAPPY, 5 = HAPPY)

Parent 1: _____ Parent 2: _____ Teen: _____

12. Available support for teen (please check boxes that apply)

	Excellent	Good	Fair	Poor	N/A
Family					
Neighbors/community					
Peers					
Teachers/coaches					
Pets					

Strengths

1. What are your teen's strengths? _____
   _____
   _____
   _____
2. What are your teen's interests? _____
   _____
   _____
   _____
3. What are your family's strengths? _____
   _____
   _____
   _____
4. Describe any cultural, ethnic, or spiritual identification or affiliations that are important to you or your family._____
   _____
   _____

Anything else that may be important to know about _____
_____
_____
_____
_____
_____