Chart # _____

Catholic Social Services of the U.P.

PARENTAL QUESTIONNAIRE

Date _____

After completion of services, we would like to send you via email a discharge questionnaire. Please provide us with your email address if you would like to participate: _____

Name_____ Age: _____ DOB _____
Last First Middle Initial

Address_____ Phone # _____
Street City State Zip Code

SS # _____ Parent/Guardian Work Phone _____ Cell _____

Insurance: _____ Secondary insurance? _____

Child's Birthplace _____ Religion _____
Ethnic Group: Caucasian _____ Native American_____ Asian _____ African-American _____

Hispanic _____ Other _____ Is child a member of a tribe?_____ If so, which one? _____

School_____ Grade _____ Teacher _____

Name of child's family doctor _____ Phone # _____

Emergency Contact Person's Name _____ Phone # _____

Allergies _____

Person Completing Form _____ Relationship _____

1) Why are you requesting counseling for your child?_____

_____

_____

_____

2) Please **check** any behavioral patterns your child is experiencing or has experienced in any of the following areas:

	Past	Current		Past	Current
Clingy	____	____	Lying or storytelling	____	____
Irritable	____	____	Wets or soils clothes	____	____
Anger	____	____	Difficulty w/changes in routines	____	____
Mood swings	____	____	Frequent Crying	____	____
Refusing to eat	____	____	Guilt/shame	____	____
Inducing vomiting	____	____	Loneliness	____	____
Hoarding food	____	____	Bossy	____	____
Over eating	____	____	Fighting	____	____
Overly active	____	____	Destructive to property	____	____
Under active	____	____	Accident prone	____	____
Afraid of others	____	____	Odd noises	____	____
Shy	____	____	Tics	____	____
Feelings easily hurt	____	____	Negative Attitude	____	____
Low self esteem	____	____	Odd behaviors	____	____

2) Please **check** any behavioral patterns your child is experiencing or has experienced in any of the following areas: (continued)

	Past	Current		Past	Current
Anxiety	____	____	Chewing on things	____	____
Panic attacks	____	____	Thumb sucking	____	____
Obsessive thoughts	____	____	Morning problems	____	____
Suicidal thoughts	____	____	Evening problems	____	____
Suicidal feelings	____	____	Difficulty going to sleep	____	____
Easily frustrated	____	____	Restless sleeping	____	____
Tantrums	____	____	Nightmares/night terrors	____	____
Aggressive behavior	____	____	Snoring	____	____
Cruel to animals	____	____	Sleep walking	____	____
Fire setting	____	____	Sleep talking	____	____
Defiant	____	____	Bed wetting	____	____
Unorganized	____	____	Muscle tics	____	____
Distractible	____	____	Stealing	____	____
Indecisive	____	____			

Which of the above would you like help with? _____

I. OUTSIDE RESOURCES:

1) Has your child ever received mental health services in the past? Yes____ No_____

(If yes, please indicate where and when) _____

2) Please list the name(s) of individuals you would like us to contact whom you have seen or are presently involved with (Therapist/School Psychologist/Social Worker/Counselor):_____

_____

II. DEVELOPMENTAL HISTORY:

1) Pregnancy Duration: Early __ On time __ Late __ Birth weight _____ Length _____

a. Complications: (Please circle)

Excessive vomiting	Staining/blood loss	Hospitalization/bed rest
Threatened miscarriage	Toxemia	Smoking during pregnancy
Infections	Operations	Alcohol consumption
Other illnesses	Drugs taken	

b. Delivery

Type of Labor ____ Spontaneous ____ Induced ____ Duration (hours) _____

Type of Delivery ____ Normal ____ Breech ____ Caesarean

c. Did your child achieve developmental milestones at a typical pace? Did he/she walk, talk, potty train, etc. at about the same time as other children of that age? (indicate early as well as delayed milestones)

_____

_____

III. MEDICAL HISTORY:

1) Have you ever been hospitalized? Yes___ No___

If yes, please list dates and reason for significant surgeries, hospitalizations, and medical procedures:

_____

_____

2) Does your child need immunizations? Yes___ No___

3) What was the date of your child's last physical exam? _____ Any abnormal results? Yes___ No___

If yes, please explain: _____

4) Is your child being treated for any illnesses? Yes___ No___

If yes, list & give dates and treatments: _____

5) Please **circle** any physical difficulties your child has or has had in the past.

Asthma	Dizziness	Rash/Hives	Epilepsy or seizures
Sinus	Diarrhea	Rheumatic fever	Constipation
Cancer	Headaches	Frequent colds	Nose bleeds
Diabetes	Sore throats	Head Injury	Vomiting
Thyroid	Muscle pain	Fainting	Cerebral Palsy
Seizures	Hypoglycemia	Lead poisoning	Persistent Physical Pain
Heart	Vision	Coordination	Strep Infections
Hearing	Sleep disorder	Eating difficulties	High fevers
Learning	Other _____		

IV. MEDICATIONS:

Please list all medications (Including anti-convulsant medications) your child takes:

Medication	Dose	Prescribing Physician	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

V. OTHER BEHAVIORS:

1) Do you think your child has smoke cigarettes, and/or used alcohol or drugs such as marijuana, inhalants, solvents, etc? Yes___ No___

If yes, please list when, frequency, effects, and responses: _____

_____

2) Do you believe your child is sexually active? Yes___ No___

VI. FAMILY:

1) Mother's Name _____ Age _____
Age at time of pregnancy _____
Mother's Occupation _____ Work Phone _____

	Past	Current
Learning Problems	____	____
Attention Problems	____	____

Mother (continued)	Past	Current
Behavior Problems	____	____
Drug or Alcohol Problems	____	____
Emotional/mental Problems	____	____
Medical Problems	____	____

2) Father's Name _____ Age _____
Age at time of pregnancy _____
Father's Occupation _____ Work Phone _____

	Past	Current
Learning Problems	____	____
Attention Problems	____	____
Behavior Problems	____	____
Drug or Alcohol Problems	____	____
Emotional/mental Problems	____	____
Medical Problems	____	____

3) Have any other blood relatives (grandparents, uncles, aunts, etc.) had any of the following problems?

	Past	Current
Learning Problems	____	____
Attention Problems	____	____
Behavior Problems	____	____
Drug or Alcohol Problems	____	____
Emotional/mental Problems	____	____
Medical Problems	____	____

4) Siblings

Name	Age	Medical, Social or School Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) Other Household Members

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____

6) Has your child always lived with your family? Yes___ No___
If no, why? _____

7) Was/is your child adopted or a foster child? Yes___ No___

On what date(s) was the child in foster placement? _____

What is the date of adoption? _____

8) Has your child ever experienced anything frightening or upsetting that may have been traumatic to them?

Yes___ No___

If yes, please describe: _____

_____

9) Does your child have a history of physical abuse? Yes___ No___

10) Does your child have a history of sexual abuse? Yes___ No___

VII. EDUCATION:

1) Has your child recently changed schools? Yes___ No___

If yes, please explain: _____

2) Is your child in special education? Yes___ No___

If yes, please describe:_____ _____

4) School related behavior	Please circle	
Does your child have difficulty paying attention in class?	Yes	No
Does your child have problems with grades?	Yes	No
Has your child been recommended for special services?	Yes	No
Is your child afraid to go to school?	Yes	No
Has your child ever repeated a grade?	Yes	No
Does your child have behavior problems in class?	Yes	No
Does your child have difficulty making friends at school?	Yes	No
Does your child complain of health problems to stay home?	Yes	No
Does your child skip school?	Yes	No

VIII. FRIENDS:

1) How well does your child get along with other people? Good _____ Fair ____ Poor _____

Describe: _____

2) Have your child's friends changed recently? Yes___ No___

If yes, describe how? _____

3) What extra-curricular activities (sports, scouts, etc) or other activities does your child enjoy?

_____

4) Please tell us what your child does well and what things you enjoy about your child:

_____

IX. LEGAL HISTORY:

1) Has your child been involved with the juvenile court system? Yes___ No___

If yes, for what reason?_____

2) Is your child on probation or in Diversion? Yes___ No___

Diversion/Probation Officer _____

X. <u>SITUATIONS THAT MIGHT AFFECT TREATMENT:</u>

1) Do you need special accommodations? Yes___ No___

If yes, please check all that apply.

Foreign Language Interpreter _____ Transportation _____

Sign Language Interpreter_____ Scheduling Accommodations _____

Other Child Care Needs _____ Other_____

XI. <u>ADDITIONAL INFORMATION</u>: Other important information you would like us to know:

_____

_____

_____

_____

_____

_____

_____

Thank you. Please feel free to talk with your therapist about any part of this form.

_____ _____

Parent/Guardian Date

_____ _____

Clinician signature Date reviewed with Parent/Guardian