Psychological and Counseling Associates
Initial Assessment Child/Adolescent Program
Parent Questionnaire

Clinician Notes:

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form _____

Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? Δ Yes Δ No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: _____
Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? Δ Yes Δ No

Is there a history of substance abuse? Δ Yes Δ No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

Δ Seizures	Δ Heart Problems	Δ Weight Problems	Δ Head Injury
Δ Asthmatic condition	Δ Chronic Fatigue	Δ Chronic Headaches	Δ Depression
Δ Chronic Hearing Loss	Δ Stomach Problems	Δ Suicidal Thoughts	Δ Surgeries

Δ Other _____

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies)**:**

Current Medications (Please list all of your child's current medications other than above)**:**

Clinician Signature:

Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? Δ Yes Δ No If yes, please explain and include dates of service, location, clinician's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

Name of medication	Prescribed by	Dose level	Side effects
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth:_____lbs._____oz. Was this a full term birth? Δ Yes Δ No If no, explain:

Did either parent use drugs or alcohol at the time of conception? Δ Yes Δ No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? Δ Yes Δ No If yes, explain:

Were there any problems after birth? Δ Yes Δ No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

Δ Did not enjoy being held	Δ Excessive restlessness	Δ Colic
Δ Feeding problems	Δ Sleep problems	Δ Head-banging
Δ Sensitive to light / noise / texture	Δ Fussy or unhappy	Δ Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____Sitting alone _____ Walking_____Put words together_____Toilet trained

D. Unusual behaviors/Speech patterns:

Δ Spinning	Δ Putting things in the mouth	Δ Repeating words or phrases
Δ Hand flapping	Δ Sniffing excessively	Δ Saying "I" for "You"

V. School/daycare History:

Did your child attend daycare? Δ Yes Δ No If yes, what was their age? _____ Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

Clinician Signature:

_____

Clinician Notes:

Name of **Current School**:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
			Δ Yes Δ No	Δ Yes Δ No

Name of **Past Schools**:	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
			Δ Yes Δ No	Δ Yes Δ NO

Has your child ever been:

evaluated for a learning disability? Δ Yes Δ No If yes, what grade?_____When? _____

placed in Special Education Classes? Δ Yes ΔNo If yes, what type of class? _____

_____

tested by the school system? Δ Yes Δ No If yes, when? _____

expelled or suspended? Δ Yes Δ No If yes, please describe: _____

_____

Does your child have a current IEP (Individual Education Plan)? Δ Yes Δ No
Does your child have a current 504 plan? Δ Yes Δ No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been:
Arrested? ΔYes ΔNo
Assigned a probation officer? Δ Yes Δ No If yes, their name: _____
Jailed? ΔYes ΔNo
Ever appeared in juvenile court? Δ Yes Δ No
or other family member ever been reported to DHR? Δ Yes ΔNo
been assigned a DHR caseworker? ΔYes Δ No
If yes, their name: _____
History of substance abuse? Δ Yes ΔNo

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

Δ Sudden death Δ Heart disease (especially dysrhythmias) Δ Diabetes
Δ Obesity Δ Narrow Angle Glaucoma Δ Seizures

Clinician Signature:

_____

Clinician Notes:

VIII. Family Psychiatric History:

Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? Δ Yes Δ No If yes, please explain:

IX. Social / Family History:

Biological mothers' full name: _____ Biological fathers' full name: _____

Biological parents marital status: Δ Married to each other Δ Divorced Δ Separated

If divorced from one another, has either remarried? Mother Δ Yes Δ No
Father Δ Yes Δ No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmothers' name: _____

Stepfathers' name: _____

List all relatives who presently live in the same household as your child (if more than 5 please list on back of this sheet):

Name	Relationship	Type of Employment / Student Grade Level
1.		
2.		
3.		
4.		
5.		

Please check any of the following stressors that presently affect your child:

Δ Family financial problems	Δ Family relationships	Δ Legal problems
Δ Child rearing problems	Δ Drug or alcohol problems	Δ Abusive behavior
Δ Health problems	Δ Employment problems	Δ School problems
Δ Peer relationships	Δ Frequent change of household	Δ Frequent moves

Δ Other problem _____

Please explain how any item you checked affects your child.

Clinician Signature:

_____

Reminder: Please bring a copy of any custody papers to the initial appointment