Owasso Counseling

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CHILD INFORMATION & PARENT QUESTIONNAIRE

Date _____________ Form Completed by ___________________________ Relation to Child __________

Child's Name _____________________ M__ F __ Birthdate ____________ Ethnicity ________________

Address ____ Age_______ Grade:_____ Gender________

Religious Preference: ______________ Work Phone (mother) ______________ (father) _______________

Child's Primary Physician _______________________ Referred by: _______________________________

Any health conditions or Diagnosis? ____

FAMILY

Father's Name _________________________________ Birthdate _____________________

Address (if different from above) ____

Occupation ______________________ Educational level ____________________ # of dependents ______

Mother's Name _________________________________ Birthdate _____________________

Address (if different from above) ____

Occupation ______________________ Educational level ____________________ # of dependents ______

Date of Marriage _________________ Present Marital Status _____________________________________

With whom does the child live? Birth parents__________________ Adoptive Parents__________________

Foster Parents _________________ Other (specify) _____________________

List all other persons living in the home:

Name	Age	Relationship to Child	Present Health

List any other people who care for the child a significant amount of time

Name	Relationship to child (grandmother, neighbor, etc.)

How serious would you say this problem is right now?

☐ NOT AT ALL SERIOUS	☐SLIGHTLY SERIOUS	☐MODERATELY SERIOUS	☐VERY SERIOUS

How likely do you think the problem is to change?

☐NOT AT ALL LIKELY	☐SLIGHTLY LIKELY	☐MODERATELY LIKELY	☐VERY LIKELY

What are your expectations and goals of participating in counseling?

____

____

____

If you experienced trauma, abuse, neglect; please describe

____

____

____

CHILD

Pregnancy and Birth: Any Complications? _____ If yes, briefly explain _______________________________

____

Has your child had any medical complications? ______ If yes, briefly explain _________________________

____

Please list any jobs or chores your child has at home or school.

(e.g., feeding the dog, making the bed, safety patrol)

____

____

____

How well does your child do these chores?

Poor		Average		Great
1	2	3	4	5
1	2	3	4	5
1	2	3	4	5

What are your child's strengths? ____

____

How many close friends does your child have? _______

How many times a week does your child do things with them? _______

How many friends in the neighborhood does your child have? _______

Compared to other children his/her age, how well does your child get along with other children?

Poor Average Great

1 2 3 4 5

What are your child's favorite play or after school activities? ___________________________________

____

List all medication and/or drugs taken within the last 6 months, both prescription and over-the-counter.

Name of Medication/drug	**Reason Taken**	**Check if currently taking**

Female Clients: Has your daughter began her menstral cycle? _______ What age?_________

Has your child ever attempted suicide? ☐ No ☐ Yes If yes, give date(s) and details.

Has anyone in your family/close friend ever attempted suicide? ☐ No ☐ Yes If yes, give name(s), relationship to your child, and details.

Has your child had previous counseling? ______If yes, please provide with whom, reason and dates.

____

What diagnoses of mental health issues have you received in the past? ____________________________

Has your child ever been inpatient for mental health reasons or substance abuse? ______________________

If yes, when, where and why was your child hospitalized? _______________________________________

____

____

FAMILY AND PERSONAL HEALTH HISTORY

Date of Last Physical Examination _____________ Child's Height ___________ Child's Weight _________

Check condition and relationship of any blood relative who has or has had any of the conditions listed below	Child being seen	Father	Paternal grandfather	Paternal grandmother	Paternal aunt/ uncle	Mother	Maternal grandfather	Maternal grandmother	Maternal aunt/ uncle	Siblings	Other
Alcoholism/Substance Abuse											
Allergies											
Birth Defects											
Cancer											
Colitis											
Depression											
Heart Attack											
High Blood Pressure											
Migraine											
Mental Illness											
Seizure Disorder											
Mental Retardation											
Learning/Attention Problems											
Suicide/Suicide Attempt											
Other (Specify)											

Family Member	Living? (yes/no)	Age	Health Good	Fair	Poor	If deceased, cause of death
Father						
Mother						
Brothers						
Sisters						

CHILD PROBLEM SCREENING FORM

Child's name: ___________________ Child's date of birth: ______________ Age: ______

Rater's name: ___________________ Relationship to Child: _________________ Today's date: _________

Directions: Below is a list of ways that children may act, think, or feel.
Please (1) circle the number showing how often your child has behaved this way in the past 3 months and
(2) circle "Yes" if it is currently a problem or "No" if it is not a problem.

		How often does this occur?					Is this a problem now?	
		Never	**Seldom**	**Sometimes**	**Often**	**Always**		
1.	Argues with others	1	2	3	4	5	Yes	No
2.	Can't concentrate or pay attention	1	2	3	4	5	Yes	No
3.	Acts sad or depressed	1	2	3	4	5	Yes	No
4.	Feeding or eating problems	1	2	3	4	5	Yes	No
5.	Teases or fights with others	1	2	3	4	5	Yes	No
6.	Is teased	1	2	3	4	5	Yes	No
7.	Appears lonely	1	2	3	4	5	Yes	No
8.	Can't sit still, hyperactive	1	2	3	4	5	Yes	No
9.	Too fearful or anxious	1	2	3	4	5	Yes	No
10.	Disobeys at home	1	2	3	4	5	Yes	No
11.	Disobeys at school	1	2	3	4	5	Yes	No
12.	Moody	1	2	3	4	5	Yes	No
13.	School problems (academic)	1	2	3	4	5	Yes	No
14.	Has temper tantrums or hot temper	1	2	3	4	5	Yes	No
15.	Acts without thinking, impulsive	1	2	3	4	5	Yes	No
16.	Threatens/tries to hurt others	1	2	3	4	5	Yes	No
17.	Has low self-esteem	1	2	3	4	5	Yes	No
18.	Toileting problems (wetting /soiling)	1	2	3	4	5	Yes	No
19.	Self-conscious or easily embarrassed	1	2	3	4	5	Yes	No
20.	Needs to be perfect	1	2	3	4	5	Yes	No
21	Threatens/tries to hurt animals	1	2	3	4	5	Yes	No
22	Threatens/tries to self	1	2	3	4	5	Yes	No