Owasso Counseling

13720 E. 86th St.
Owasso, OK 74055

Laura Long, MA, LPC
(918) 698-2281

CHILD INFORMATION & PARENT QUESTIONNAIRE

Date _____ Form Completed by _____ Relation to Child _____

Child's Name _____ M__ F __ Birthdate _____ Ethnicity _____

Address _____ Age_____ Gender_____

Home Phone _____ Work Phone (mother) _____ (father) _____

Child's Primary Physician _____ SSN: _____

Who referred the child? _____ Address _____

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 _____

_____

At what age did your child:

Sit Without Support _____ Walk _____ Begin Talking _____ Stay Dry Through the Night ____

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? None ____ 1____ 2-3 ____ 4 + ____

How many times a week does your child do things with them? None ____ 1____ 2-3 ____ 4 + ____

How many friends in the neighborhood does your child have? None ____ 1____ 2-3 ____ 4 + ____

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.

_____

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

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

_____

_____

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

_____

_____

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						

DISCIPLINARY STRATEGIES

Who generally disciplines the child? _____

What methods are used? _____

Are these methods effective? _____

Do parents agree on methods of discipline? _____ Elaborate, if no _____

_____

SCHOOL HISTORY

If your child has ever been to school (including Pre-K/kindergarten and grade school) complete the following for all classes beginning with nursery and ending with current placement. Please indicate if your child is in a special class (gifted, learning disabled, emotionally handicapped, etc.)

Grade	School	Comments Regarding Behavior/Adjustment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current School Performance (for children aged 6 and older)

	Failing	Below Average	Average	Above Average
Reading	_____	_____	_____	_____
Writing	_____	_____	_____	_____
Arithmetic or Math	_____	_____	_____	_____
Spelling	_____	_____	_____	_____

Other Academic Subjects (history, science, foreign language, geography, etc.)

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PARENTAL CONCERNS

What do you feel is your child's main problem and reason for seeking services?

_____

_____

What do you feel caused your child's problem? _____

_____

_____

What have you been told by doctors, teachers, and/or others about your child's problems? _____

_____

_____

Has this child had any other mental health evaluations or treatment? _____

_____

_____

Has any member of the child's immediate family had mental health treatment? _____

_____

_____

Other comments _____

_____

_____

_____

(Signed) Parent or Guardian

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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