FAMILY PSYCHOLOGICAL SERVICES
of Lakeland

COUNSELING PARENT QUESTIONNAIRE

CHILD'S NAME: _____ **DATE COMPLETED:** _____

DATE OF BIRTH: _____ **AGE:** _____

YOUR NAME: _____ **RELATIONSHIP TO CHILD:** _____

PARENTS' NAMES: _____

MOTHER'S ADDRESS AND PHONE: _____

_____

FATHER'S ADDRESS AND PHONE: _____

_____

MOTHER'S OCCUPATION: _____ **YEARS OF EDUCATION:** _____

FATHER'S OCCUPATION: _____ **YEARS OF EDUCATION:** _____

PARENTS MARITAL STATUS (CHECK ONE): ☐ **TOGETHER** ☐ **SEPARATED** ☐ **DIVORCED** ☐ **OTHER:** _____

STEP-MOTHER'S NAME: _____

STEP-FATHER'S NAME: _____

WHO REFERRED YOU TO FAMILY PSYCHOLOGICAL SERVICES? _____

ARE BOTH PARENTS AWARE THAT THE CHILD IS PARTICIPATING IN COUNSELING? _____

DESCRIBE THE PROBLEMS WHICH HAVE LED YOU TO SEEK THIS CONSULTATION FOR YOUR CHILD: _____

_____

_____

WHAT DO YOU, PERSONALLY, BELIEVE TO BE THE MOST IMPORTANT FACTORS CAUSING THESE PROBLEMS? _____

_____

HAVE THERE BEEN ANY FAMILY CHANGES OR DIFFICULTIES (NEW BABY, DIVORCE, FAMILY ARGUMENTS, ETC.) WHICH MAY BE RELATED TO THESE PROBLEMS? _____

IF SO, PLEASE EXPLAIN: _____

_____

_____

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WHAT SOLUTIONS (HELPFUL OR UNHELPFUL) HAVE YOU TRIED TO RESOLVE THE ABOVE CONCERNS?

HAVE YOU OR YOUR CHILD HAD THERAPY IN THE PAST? IF SO, PLEASE PROVIDE TREATMENT PROVIDERS NAMES, DATES OF SERVICE, WHAT YOUR CHILD WAS SEEN FOR, AND THE RESULTS.

DESCRIBE YOUR CHILDS STRENGTHS AND BEST BEHAVIOR TRAITS:

WHAT ARE YOUR EXPECTATIONS FROM THERAPY AND THE THERAPIST?

IF YOU HAD A CRYSTAL BALL AND WERE ABLE TO LOOK INTO THE FUTURE, YOU WOULD SAY THERAPY HAS BEEN WORTH IT BECAUSE (LIST CONCRETE CHANGES YOU WOULD LIKE TO SEE):

WHAT OTHER THINGS WOULD YOU LIKE TO SEE CHANGE IN YOUR LIFE AND YOUR FAMILY'S LIFE?

DO YOU FORESEE ANY OBSTACLES TO ACHIEVING YOUR GOALS AND/OR CHANGES?

How long will therapy need to last to achieve the changes and/or goals you want?

Write down a target date:

Child Behavior Inventory

Below are a series of phrases that describe children's behavior. Please circle the number describing how often the behavior currently occurs with your child, and circle either "Yes" or "No" to indicate whether the behavior is currently a problem.							
Question:	**How often does this occur with your child?**					**Is this a problem for you?**	
	Never	**Seldom**	**Sometimes**	**Often**	**Always**		
Dawdles in getting dressed	1	2	3 4	5 6	7	Yes	No
Dawdles or lingers at mealtime	1	2	3 4	5 6	7	Yes	No
Refuses to eat food presented	1	2	3 4	5 6	7	Yes	No
Refuses to do chores when asked	1	2	3 4	5 6	7	Yes	No
Slow in getting ready for bed	1	2	3 4	5 6	7	Yes	No
Refuses to go to bed on time	1	2	3 4	5 6	7	Yes	No
Does not obey house rules on his or her own	1	2	3 4	5 6	7	Yes	No
refuses to obey until threatened with a consequence	1	2	3 4	5 6	7	Yes	No
Acts defiant when told to do something	1	2	3 4	5 6	7	Yes	No
Argues with parents about rules	1	2	3 4	5 6	7	Yes	No
Gets angry when does not get own way	1	2	3 4	5 6	7	Yes	No
Has temper tantrums	1	2	3 4	5 6	7	Yes	No
Sasses adults	1	2	3 4	5 6	7	Yes	No
Whines	1	2	3 4	5 6	7	Yes	No
Cries easily	1	2	3 4	5 6	7	Yes	No
Yells or screams	1	2	3 4	5 6	7	Yes	No
Hits parents	1	2	3 4	5 6	7	Yes	No
Destroys toys and/or other objects	1	2	3 4	5 6	7	Yes	No
Is careless with toys and/or other objects	1	2	3 4	5 6	7	Yes	No
Steals	1	2	3 4	5 6	7	Yes	No

CHILD BEHAVIOR INVENTORY (CONTINUED)

QUESTION:	HOW OFTEN DOES THIS OCCUR WITH YOUR CHILD?					IS THIS A PROBLEM FOR YOU?	
	NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS		
LIES	1	2	3 4	5 6	7	YES	NO
TEASES OR PROVOKES OTHER CHILDREN	1	2	3 4	5 6	7	YES	NO
VERBALLY FIGHTS WITH FRIENDS HIS OR HER OWN AGE	1	2	3 4	5 6	7	YES	NO
VERBALLY FIGHTS WITH SIBLINGS	1	2	3 4	5 6	7	YES	NO
PHYSICALLY FIGHTS WITH FRIENDS HIS OR HER OWN AGE	1	2	3 4	5 6	7	YES	NO
PHYSICALLY FIGHTS WITH SIBLINGS	1	2	3 4	5 6	7	YES	NO
CONSTANTLY SEEKS ATTENTION	1	2	3 4	5 6	7	YES	NO
INTERRUPTS OTHERS	1	2	3 4	5 6	7	YES	NO
IS EASILY DISTRACTED	1	2	3 4	5 6	7	YES	NO
HAS A SHORT ATTENTION SPAN	1	2	3 4	5 6	7	YES	NO
FAILS TO FINISH TASKS OR PROJECTS	1	2	3 4	5 6	7	YES	NO
HAS DIFFICULTY CONCENTRATING ON ONE THING	1	2	3 4	5 6	7	YES	NO
IS OVERACTIVE, RESTLESS, AND/OR FIDGETY	1	2	3 4	5 6	7	YES	NO
ACTS IMPULSIVELY (SPEECH OR ACTIONS)	1	2	3 4	5 6	7	YES	NO
HAS PROBLEMS MAKING FRIENDS	1	2	3 4	5 6	7	YES	NO
HAS PROBLEMS KEEPING A CLOSE FRIEND	1	2	3 4	5 6	7	YES	NO
BED WETTING	1	2	3 4	5 6	7	YES	NO
SOILING UNDERCLOTHES	1	2	3 4	5 6	7	YES	NO
REPEATEDLY CHECKS AND RECHECKS THINGS	1	2	3 4	5 6	7	YES	NO
FREQUENTLY ERASES WORK AT SCHOOL OR HOME	1	2	3 4	5 6	7	YES	NO
HAS ROUGH OR CHAPPED HANDS	1	2	3 4	5 6	7	YES	NO
HAS FREQUENT AND/OR EXCESSIVE FEARS	1	2	3 4	5 6	7	YES	NO
HAS TO RE-READ OR RE-WRITE OFTEN	1	2	3 4	5 6	7	YES	NO
IS EXCESSIVELY CONCERNED ABOUT ILLNESS AND/OR DISEASE	1	2	3 4	5 6	7	YES	NO
FREQUENTLY PULLS AT HAIR OR BITES FINGERNAILS	1	2	3 4	5 6	7	YES	NO
SEEMS SAD OR DEPRESSED	1	2	3 4	5 6	7	YES	NO
SEEMS ANXIOUS OR NERVOUS	1	2	3 4	5 6	7	YES	NO

FOR THE FOLLOWING LIST, READ EACH PROBLEM AND CHECK FOR PERSISTENCE:	PERSISTENCE		
PROBLEM	NOT A PROBLEM	PRESENT IN MOST SITUATIONS	PRESENT IN ALL SITUATIONS
OFTEN FIDGETS WITH HANDS OR FEET, SQUIRMS IN SEAT (IN ADOLESCENTS, MAY BE LIMITED TO SUBJECTIVE FEELINGS OF RESTLESSNESS)			
HAS DIFFICULTY REMAINING SEATED WHEN REQUIRED TO DO SO			
IS EASILY DISTRACTED BY EXTRANEOUS STIMULI			
HAS DIFFICULTY WAITING TURN IN GAMES OR GROUP SITUATIONS			
OFTEN BLURTS OUT ANSWERS TO QUESTIONS BEFORE THEY HAVE BEEN COMPLETED			
HAS DIFFICULTY FOLLOWING THROUGH ON INSTRUCTIONS FROM OTHERS (NOT DUE TO OPPOSITIONAL BEHAVIOR OR FAILURE TO COMPREHEND) I.E. FAILS TO FINISH CHORES			
HAS DIFFICULTY SUSTAINING ATTENTION IN TASKS OR PLAY ACTIVITIES			
OFTEN SHIFTS FROM ONE UNCOMPLETED ACTIVITY TO ANOTHER			
HAS DIFFICULTY PLAYING QUIETLY			
OFTEN TALKS EXCESSIVELY			
OFTEN INTERRUPTS OR INTRUDES ON OTHERS; I.E. BUTTS INTO OTHER CHILDREN'S GAMES			
OFTEN DOES NOT SEEM TO LISTEN TO WHAT IS BEING SAID TO HIM OR HER			
OFTEN LOSES THINGS NECESSARY FOR TASKS OR ACTIVITIES AT SCHOOL OR HOME; I.E. PENCILS, BOOKS, ASSIGNMENTS			
OFTEN ENGAGES IN PHYSICALLY DANGEROUS ACTIVITIES WITHOUT CONSIDERING POSSIBLE CONSEQUENCES (NOT FOR THRILL-SEEKING) I.E. RUNS INTO THE STREET WITHOUT LOOKING			

IMPORTANT QUESTIONS WE MUST ASK

HAS YOUR CHILD EVER HAD SUICIDAL IDEATIONS? NO YES IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER PLANNED TO HURT HIMSELF OR HERSELF? NO YES IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER ATTEMPTED TO HURT HIMSELF OR HERSELF? NO YES IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER FELT LIKE HE OR SHE WANTED TO SERIOUSLY HURT OR HARM SOMEONE ELSE? NO YES IF YES, PLEASE EXPLAIN:

DO YOU HAVE WEAPONS IN YOUR HOME OR ACCESS TO WEAPONS? NO YES IF YES, WHO HAS ACCESS TO THEM AND WHAT ARE THE SAFETY PROTOCOLS AROUND THEM:

IS THERE ANY HISTORY, PAST OR PRESENT, OF ABUSE OR VIOLENCE? NO YES IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD IN THE PAST OR IS CURRENTLY USING ANY ILLEGAL DRUGS, TOBACCO, OR ALCOHOL OR IS THE REASON YOU ARE SEEKING THERAPY SERVICES SUBSTANCE ABUSE RELATED? NO YES IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD EVER WITNESSED OR EXPERIENCED A TRAUMA? DOES YOUR CHILD HAVE REOCCURRING NIGHTMARES, FLASHBACKS, OR AVOIDS ANYTHING THAT IS UNCOMFORTABLE OR PAINFUL? NO YES IF YES, PLEASE EXPLAIN:

Are you Concerned your child may see or hear things that Do Not appear to be Real? No Yes If Yes, Please Explain:

Has your child ever been Arrested, Been involved with the Juvenile Justice System, or is Engaging in behaviors that put him or her at risk? No Yes If Yes, Please Explain:

Do you have any Concerns about your child's Sexuality, Gender, or Sexual Development?

Family Information

Describe your Child's Relationship with the Following:

Mother:

Father:

Is this Typically how you would have described your relationship in the past or has there been a change?

Siblings (Biological and /or Step-Siblings). Please list Names, age, and whether or not they live with your child.

Names	Age	Lives with your Child	Relationship

Significant Other:

Other(s):

If Parents are divorced, What is the Current visitation schedule?

If parents are divorced, Please describe the Parents' relationship with one another?

Has the child ever Lived with anyone other than yourself?

Who provides the Primary Care for your child?

Type of Discipline used:

Does your family belong to any Religious or Spiritual Groups? No Yes If Yes, What is your Level of Involvement:

Who else do you consider to be Part of or Supportive to your family (people or affiliations):

Does your family have any pets? No Yes If Yes, Please list the Names, Types, and Relationship to each pet:

How is your child around Pets?

What Responsibilities does your child have at home?

If your child is age 15 years old or above, What other skills do you think your child needs to be independent? How is he or she learning them? What else does he or she need to gain independence?

Does your child have his or her own Cell Phone? No Yes If Yes, What are the Rules around your child's cell phone use and Who enforces those rules?

Developmental History

Mother's health during pregnancy (Physical and Emotional):

Was the Mother prescribed any medication during pregnancy? No Yes If Yes, What?

Did the Mother use alcohol, cigarettes, or illegal substances during pregnancy? No Yes If Yes, What?

Length of pregnancy (Premature/Full-Term/Late):

Any problems with delivery?

Did your child have any medical problems at the time of birth or shortly after?

Number of days the baby was in the hospital?

Describe your baby's temperament the first months of life:

Developmental Milestones

Please list the approximate age at which you child did the following:

Weaned from Nursing or Bottle:	**Talked:**
Slept through the night:	**Walked:**
Toilet Trained:	

Education

Did your child attend Pre-School?

What is the Name of your child's Current School?

What Grade is your child currently in?

Does your child have an ESE placement No Yes If Yes, Which category of ESE (SLD, EH, EMH, etc.):

Has your child Skipped or Repeated any grades?

What is the number of days your child has been Absent this school year?

What is the number of days your child has been Tardy this semester:

What were your child's Grades on his last report card?

Has your child had any In or Out of school suspensions?

Has your child had any school placement Disruptions due to Behavior Problems?

MEDICAL HISTORY

HAS YOUR CHILD EVER BEEN HOSPITALIZED? NO YES IF YES, FOR WHAT CONDITION?

IS YOUR CHILD TAKING ANY MEDICATION? NO YES IF YES, WHAT MEDICATIONS?

DOES YOUR CHILD HAVE ANY ALLERGIES (FOOD, MEDICATIONS, OR ENVIRONMENT)?

DOES YOUR CHILD HAVE ANY CURRENT MEDICAL CONDITIONS?

HAS YOUR CHILD EVER SUFFERED A HEAD INJURY? NO YES IF YES, DID YOUR CHILD EXPERIENCE CONCUSSION SYMPTOMS OR SUFFER ANY LOSS OF CONSCIENTIOUS? PLEASE EXPLAIN:

NAME OF PRIMARY CARE PHYSICIAN AND PRACTICE:

DATE OF LAST PHYSICAL EXAM?

WERE ANY PROBLEMS NOTED WITH YOUR CHILD AT THE LAST PHYSICAL EXAM? NO YES IF YES, WHAT?

DOES YOUR CHILD HAVE ANY SENSITIVITY TO STIMULI (NOISES, SMELL, OR TASTE, ETC.)?

DOES YOUR CHILD HAVE ANY DIFFICULTIES WITH ANY OF THE FOLLOWING (CHECK ALL THAT APPLY):

	SLEEP		SEIZURES		ROCKING OR HEAD BANGING
	APPETITE		HEADACHES		SOILING OR LACK OF BOWL CONTROL
	STOMACHACHES		WEIGHT LOSS OR GAIN		SERIOUS INJURY FROM AN ACCIDENT

HAS ANYONE IN YOUR IMMEDIATE OR EXTENDED FAMILY BEEN TREATED FOR ANY MENTAL HEALTH TREATMENT OR EXPERIENCED ANY LEARNING DISABILITIES? IF SO, PLEASE LIST WHICH FAMILY MEMBER AND THEIR CONDITION, IF KNOWN:

ADDITIONAL BACKGROUND HISTORY

DO YOU OR ANYONE IN THE IMMEDIATE FAMILY HAVE A HISTORY OF PHYSICAL, SEXUAL, OR EMOTIONAL ABUSE?

HAS YOUR CHILD EVER SET A FIRE?

HOW MANY HOURS A DAY DOES YOUR CHILD WATCH TV?

HOW MANY HOURS A DAY IS YOUR CHILD ON THE COMPUTER? **ON THE INTERNET?**

WHAT DOES YOUR CHILD DO IN HIS OR HER SPARE TIME?

HOW MANY HOURS A DAY IS YOUR CHILD UNDER YOUR SUPERVISION?

IS THERE ANY ADDITIONAL INFORMATION THAT YOU THINK IS IMPORTANT TO SHARE ABOUT YOUR CHILD?

PARENT SIGNATURE: _____ **DATE: _____**