Parent's Questionnaire for Adolescent Client

NAME: _____ DOB: _____

Why is your child coming in today? _____

I. Education

1. Name of your child's school_____ Grade level_____
2. Is your child: gifted_____ college prep_____ technical_____ other _____
3. Are your child's grades: above average__ average __ less than average__ failing __
4. Has your child ever been left back? Yes___ No___ If yes, what grade did your child repeat?____
5. How often does your child get detentions? daily___ weekly___ monthly ___ rarely ___ never___
6. How do you think your child feels toward school? _____

II. Social

7. Does your child have a group of friends to hang out with? Yes____ No____
8. Does your child have a best friend? Yes____ No____
9. Do you think that your child is: very popular__ well liked __ liked__ a tag-a-long __ a loner__ other __ explain__
10. Do most kids in your child's group drink alcohol Yes__ No__ do drugs Yes__ No__ smoke cigarettes Yes__ No __
11. What activities does your child enjoy with his/her friends? _____
12. What activities does your child enjoy when alone? _____
13. Do you like ___ or dislike ____ your child's friends

III. Family

14. With whom does your child currently live? _____
15. As parents you are: still married and live together __separated__ divorced __ never married __remarried __
16. How many brothers or half brothers does your child have? _____ ages _____
17. How many sisters or half sisters does your child have? _____ ages _____
18. Are there step children in this family? List ages _____
19. As a parent, briefly describe your relationship with your child. _____
20. Whose idea was counseling? your idea_____ child's ____ school _____court _____other_____
22. What do you think about counseling? _____

IV. History

23. Current or important medical issues? _____
24. Current medications and dosages? _____
25. What are your child's current stressors? _____
26. What are your child's past stressors? _____
27. Has your child ever experienced a traumatic event? _____
28. Has your child every experienced an abusive event? _____
29. Does your child have difficulty controlling anger? _____
30. Does your child have substance abuse issues? _____
31. To your knowledge, has your child ever had thoughts of self-injury? _____
32. To your knowledge, does your child have thoughts of self-injury currently? _____
33. To your knowledge, has your child ever had thoughts of hurting someone else? _____

The following is a list of behaviors, thoughts or feelings. Please check those that you feel describe your child's personality.

Positive Personality Traits

__ confident
__ flexible
__ loyal
__ sensitive
__ respectful
__ optimistic
__ creative
__ honest
__ happy
__ organized
__ assertive
__ responsible
__ playful
__ adjusts well
__ compassionate
__ helpful
__ understanding
__ insightful
__ cooperative
__ loving
__ calm
__ independent

Negative Personality Traits

__ jealous
__ worries
__ angry
__ frightened
__ lazy
__ sensitive
__ low self esteem
__ lonely
__ bored
__ sad
__ tired
__ fighting
__ afraid to leave caretaker
__ strong willed
__ lying
__ stealing
__ cheating
__ hurting animals
__ setting fires
__ defies authority
__ picky eater
__ wets bed
__ vomits when upset
__ sick often
__ pulls own hair
__ bites nails
__ frequent constipation
__ headaches
__ stomach aches
__ crying spells
__ problems sleeping
__ easily distracted
__ problems concentrating
__ can't sit still
__ impulsive
__ does not follow instructions
__ refuses to go to school
__ trouble in school
__ legal problems

_____ _____
Parent Signature Date