Parent Questionnaire for Children/Adolescents

Minnesota Clinic for Health and Wellness

In order to better serve you and your child, there are some things that would be helpful for us to know about your family. Please answer each question as completely as you can.

Background information:

Client's name: _____ Date of Birth:_____

Biological/Adoptive Parent's name:	Age	Education	Occupation
_____	____	_____	_____
_____	____	_____	_____

Siblings Names:	Age	Grade	School
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

List any other people living in the home

_____

Dates of marriage and/or divorce of parents:

_____

If either of the client's parents are divorced and remarried, please list date of the remarriage, name of the new spouse, and name and ages of any step-siblings:

_____

_____

If the client's parents are divorced, what is the parenting time arrangement?

_____

History of Problem/Concern:

What is the problem/concern your child is seeking therapy for?

When did these concerns first become noticeable?

What changes in your child have you or others noticed that seem related to the problem?

How have you tried to resolve the problem?

Are there any major incidents or events (moving, death of a family member, bullying, trauma, significant transitions) which seem to have affected your child? Please describe the impact you have noticed.

Are there any other family stressors?

Family Interaction:

Describe your child's relationship with you (and other parent, if applicable):

Describe your child's relationship(s) with siblings:

What do you do together as a family?

How are decisions made in your family?

Please describe the style of discipline used in your family?

How does your family express feelings?

How often are there conflicts in your family? What are they usually about?

Family History:

What is your family's cultural background (ethnic/racial origin, religion, etc/)?

Is there a history of medical illness (diabetes, cancer, heart disease, etc.) in your family ? If so, please list the illness and the family member(s) who have the illness:

Is there a history of mental health concerns (depression, anxiety, ADHD, schizophrenia, etc.) in your family? If so, please list the concerns and the family member(s) who have the mental health diagnosis:

Developmental History:

Was your child a planned pregnancy? How did parents react to the pregnancy?

Were there any complications during the pregnancy/birth? If yes, please describe:

Please describe your child's emotional/behavioral adjustment (responses, activity level, etc.)

As an infant:

As a toddler:

As a preschooler:

Elementary age:

Middle school age:

High school age:

At what age did your child:

Say a single word?_____ Simple sentences?_____ Complete sentences?_____

Crawl?_____ Walk?_____ Complete toilet training?_____

Please describe any problems with toilet training:

Describe any issues with wetting or soiling the bed after your child was toilet trained:

How well did your child tolerate normal separations before school age?

Please describe eating and sleeping patterns:

As an infant –

As a toddler –

As a preschooler –

Childhood or later years –

If you have noticed any unusual eating patterns (fasting, constant dieting, eating a lot, not eating at all) or changes to your child's eating habits, please describe:

List childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents, injuries, surgeries, seizures, or other medical concerns:

Educational History:

In what school and grade is your child currently enrolled?

Have there been any problems with peers or teachers (academic, behavioral, emotional, social)? If yes, what are the concerns and when did they begin?

What kinds of grades does your child usually get? Have there been any recent changes?

Has your child ever been assessed for learning difficulties or been in special classes? If yes, please describe:

Has your child ever been suspended or expelled from school? If yes, please describe why this happened and how it was handled:

Treatment History:

Has your child previously been seen by a mental health or chemical dependence professional? If yes, please fill in the following information:

Name of Professional	Dates of Service	Reason for Service
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever seen a school counselor or school psychologist? If so, please explain reason(s) and dates:

Has your child ever been placed outside the home for mental health, emotional, and/or behavioral reasons (foster care, residential treatment, juvenile detention, etc.)? If yes, please explain:

What goals do you have for your child's treatment process?

Is there anything else you can think of that would be helpful for me to know?