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INITIAL CONSULTATION PARENT QUESTIONNAIRE

Name: _____Date of Birth: _____

Your child's main problem or reason you are seeking consultation today?

What would you like to get out of this visit?

Describe any other behavioral or emotional problems:

Describe the impact on the family:

Have you sought counseling or psychiatric medication for your child?
If yes, please indicate:

Whom?

When?

Why?

Was it helpful?

Is your child taking any psychiatric medications?
If yes,

What?

Why?

Is it helpful?

Name(s) of the Prescribing psychiatrist?

Has your child ever been psychiatrically hospitalized?
If yes,

When?

Where?

Why?

Was it helpful?

Family History:

Who does your child live with?

Ages and relationship to child:

If parents are separated, custody arrangement and amount of contact with each parents:

Has there been any abuse of the child:

___Physical

___Sexual

___Emotional

___Neglect

If yes to any of the above, please describe briefly:

Any current or past history of legal actions?

Indicate if any family members or relatives have any of the followings: Please indicate whom:

___ADD/ADHD:

___Alcohol/Drug abuse:

___Depression:

___Anxiety/OCD/Phobias, etc:

___Eating disorders:

___Suicide:

___Serious illness:

___Physical handicaps:

___Abuse victim:

___Abusive to others:

___Aggressive behaviors:

Additional comments:

Medical History:

Does your child ever had any significant medical problems or been hospitalized, including past surgeries?
If yes, please list:

Is your child currently in treatment for any medical condition?

Is your child currently taking any medications, including herbal and over the counter medicines?
If yes, please list:

Does your child have allergies to any type of food or medications?

Name of primary care physician and any specialty physician, your child is currently under their care:

Is your child currently working with any other health professional, such as nutritionist, acupuncturist, etc?

If yes, please indicate name(s) and phone number(s):

Developmental History:

Problems with pregnancy or delivery:

Problems with developmental mile stones; such as motor development, speech, toilet training, etc.:

Alcohol and Drug Use:

Does your child use alcohol, drugs or cigarettes?

If yes, how much and how often and do you consider this to be a problem for your child?

Indicate any previous treatment for alcohol or drug use:

Has your child had any history of legal problems?
If yes, when?

For what?

Please check items below that apply to your child's current condition:

Please note specifics that apply:

___Headaches:

___Dizziness:

___Stomach/bowel problems:

___Pain:

___Tremors/Tics:

___Eat little to lose weight:

___Vomit food intentionally:

___Binge and/or overeat:

___Sleep Problems:

___Falling sleep:

___Staying sleep:

___Sleeping too much: average number of hours:

___Sleeping too little: average number of hours:

___Weight loss:

___Weight gain:

___Loss of appetite:

___Low energy

___Feelings of worthlessness:

___Feeling apart from others:

___Memory Problems:

___Concentration Problems:

___Feeling depressed:

___Threatened suicide:

___Attempted suicide:

___Self injury:

___Crying a lot:

___Unable to have a good time:

___Anxiety:

___Fears:

___Bed time fears:

___Always worried:

___Nightmares:

___Panic attacks:

___Recurring unwanted thoughts and behaviors:

___Restlessness:

___Decreased need for sleep:

___Mood swings:

___Excess energy&/or feeling wired:

___Confusion:

___Elated/euphoric mood:

___Excessive spending:

___Racing/overflow of thoughts:

___Irritable:

___Impulsive behaviors:

___Grandiose thoughts/plans:

___Anger/explosiveness:

___Restlessness and unable to sit still:

___Act without thinking:

___Difficulty paying attention:

___Low motivation:

___Short attention span:

___Easily frustrated:

___Easily distracted:

___Daydream or fantasize a lot:

___Temper outbursts:

___Uncooperative:

___Back talks:

___Hard to admit mistakes:

___Swears a lot:

___Easily annoyed by others:

___Rebellious attitude or behaviors:

___Damaged property:

___Want to run away:

___Stolen things:

___Have run away from home:

___Sneak out at night:

___Hurt animals physically:

___Hurt People physically:

___Problem with the law:

___Been arrested, in jail or on probation:

___Fire setting:

___Bedwetting/daytime wetting:

___Soiling in pants:

___Hear voices other do not hear:

___See things other do not see:

___Strange or unusual behaviors:

___Feel people plot against me:

___Constant suspiciousness/distrust:

___Usual thoughts:

___Someone physically harming you:

___Thoughts of physically harming another person:

___Violent/aggressive behaviors:

___Physical abuse:

___Sexual abuse:

___Relationship problems:

___Financial problems:

___Conflicts in family:

Check items that apply:

___Prefers to be alone:

___Alone a lot, but dislikes this and feels lonely:

___Problem getting along with classmates:

___Problem getting along with teachers:

___Difficulty getting along with siblings:

___Problem getting along with (step) parents:

___Family member uses drugs or drinks too much:

___Family member or friend tried suicide:

___Being neglected:

___Getting picked on or bullied by friends or family:

___Has a best friend:

___Has a lot of friends:

___Has a steady boyfriend/girlfriend:

___Sexually active:

___Shy:

___Poor grades:

___Learning problems:

___Cutting School or classes:

___Has been on detention, suspended, or expelled from school:

___Getting into fights in school:

___Plays with younger kids:

___Plays with older kids:

___Plays with "problem kids":

___Poor relation with peers:

___Over sensitive:

School Issues:

___Resource classes/Special education:

___Gifted program:

___Speech therapy:

___Continuation School:

___Home study:

___Independent study:

Family Stresses:

___Marital problems:

___Marital separation:

___Divorce:

___Custody dispute:

___Financial problems:

___Housing problems:

___Legal stresses:

___Death of a friend or family/relative:

___Death of a pet:

___Family illness:

___Parent's drugs or alcohol use:

___Others:

Forms of Discipline used by parents:

___Time out:

___Loss of privilege:

___Grounding:

___physical punishment:

___Extra chores:

___Rewards/incentives:

___Others:

Additional Comments:

_____ _____

Patient(Parent/Guardian) ***signature*** Witness

_____ _____

Patient (Parent/Guardian) ***print name*** Date