Parent Questionnaire

Child's Name______________________________ Today's Date________________

Child's Date of Birth______________ Age______ Gender: M______ F______

Your Name______________________________ Relationship to Child__________

Presenting Concerns and Mental Health Services

What problems have your child/ family had that led you to seek help?

What kind of service or help are you interested in?

How were you referred to Dr. Hart?

Please list any mental health services your child or family has received.			
		Provider/ Agency	Dates of Service
	Psychological assessment		
	Individual or family counseling		
	Psychiatric medication		
	Residential treatment or foster care		
	Chemical dependency treatment		
	Psychiatric hospitalizations		

Family History

Please describe your family.				
	Parent name and relationship to child		Occupation	
	Parent name and relationship to child		Occupation	
	Parent name and relationship to child		Occupation	
	Sibling names and ages			
	Persons living in your child's home			
	Parent separation, divorce, death, or remarriage			

What do you see as your child's strengths?

What do you see as your families' strengths?

Educational/ Learning History

	Name of School	
	Grade	
	Teacher	

What are the primary problems, if any, that your child has had in school?

Please check all items that apply to your child and add any additional information.		
	Problems with learning in school	
	Evaluated for learning problems	
	Has received special education services	
	Problems with behavior at school	
	Has been absent from school a lot	
	Has been suspended or expelled	
	Problem with speech or language usage	
	Poor concentration	
	Difficulty following directions	
	Memory problems	

Behavioral, Emotional, Social History

Please check all items that apply to your child and add any additional information.		
	Problems with appetite or eating	
	Sleep Problems	
	Low energy	
	Few interests or activities	
	Overactive	
	Irritable or easily upset	
	Problems with anger or aggression	
	Self-destructive behavior	
	Nervous manners, movements, or sounds	
	Repetitive habits or tics	
	Sadness or depression	
	Socially isolated	
	Difficulty getting along with peers	
	Uncooperative with others	
	Problems with anxiety	
	Fears	
	Harms self	

	Unusual behaviors	
	Leaves home without permission	
	Legal involvement	
	Chemical use	
	Physical or sexual abuse	

Do you have concerns about your child's relationships with other children or adults?

Developmental Health and Medical History

	Primary care physician	

What concerns do you have about your child's development or current health?

Please check all items that apply to your child and add any additional information.				
	Complications during pregnancy			
	Premature birth	Number of weeks:		
	Complications during labor			
	Health problems at birth			
	Use of drugs or alcohol during pregnancy			
	Problems in infancy (e.g. sleep, feeding)			
	Walked Alone:	Early	On-Time	Late
	First Words:	Early	On-Time	Late
	Speech Understood by Strangers:	Early	On-Time	Late
	Current health problems			
	History of hospitalizations			
	Serious injuries			
	Head injury or loss of consciousness			
	Seizures			
	Current medications			
	Current problems with toileting (bedwetting, constipation, etc)			
	Current motor coordination problems			
	Current medications and doses			