

Clarity Psychological Services, LLC

PARENT QUESTIONNAIRE

In order to best be able to help you and your child, we need to know some things about your family. Please answer each question as completely as you can and explain any “yes” or “no” answers.

Background Information:

Client’s name: _____ Date of Birth: _____

Biological Parents’ Name:	Age	Education	Occupation

Sibling Names	Age	Education	Occupation

List any other living in the home:

Dates of marriage and/or divorce of biological parents:

If the client’s biological parents are divorced, please fill in the following information:

Name of Parent	Date(s) of Marriage	Name of Second Spouse

Custody and visitation arrangements:

History of Problem:

What is the problem? Why are you bringing in your child for therapy?

When and how did you first notice the problem?

How have you tried to resolve the problem?

Please describe any major incidents, such as moving or the death of a family member, which seems to have affected your child. What was his/her reaction?

Family Interaction:

Describe your relationship(s) with the client's sibling(s):

What do you do together as a family?

How are decisions made in your family?

What kind of discipline is used in your family? Who is the “family disciplinarian”?

How does your family express feelings?

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

How would you describe your child’s personality and temperament?

Family History:

What is your family cultural background (ethnic or racial origin, religion, etc.)?

Please note any history of psychiatric illness (such as depression, learning disability, schizophrenia, manic depression, attention deficit, etc.) in your family?

Is there any history of alcohol and/or drug use or dependency in your family?

Developmental History:

Was the client a planned child? How did parent(s) react to the pregnancy?

Please describe any complications during the pregnancy and/or birth of the client, if any.

Please describe the client's emotional and behavioral adjustment (response, activity level):

as an infant: _____

as a toddler: _____

as a preschooler: _____

during grade school: _____

during junior high: _____

during high school: _____

At what age did the client:

say a single word? _____ simple sentences? _____ complete sentences? _____

crawl? _____ walk? _____ bladder trained? _____

bowel trained? _____ interested in other children? _____

How well did the client tolerate normal separations before school age?

Have you noticed any unusual eating patterns (such as fasting, constant dieting, eating a lot at one time followed by not eating, etc.) or changes in the client's eating habits? If yes, please describe:

Educational History:

What school is the client enrolled in? _____ Grade? _____

Has the client repeated or skipped any grades? Yes No

Have there been any academic, behavioral, or emotional problems with peers or teachers? If yes, when did the problems begin? What were they?

What kinds of grades does the client usually get? Describe any recent changes?

Has the client ever been assessed for learning problems or been in special classes? If yes, please describe:

Has the client ever been suspended or expelled from school? If yes, please describe why this happened and how you handled it:

Treatment History:

Has the client ever been taken to a mental health or chemical dependence professional before? If yes, please fill in the following information:

Name of Professional	Dates of Service	Reason for Services
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Has the client ever seen a school counselor or school psychologist? If yes, please explain, including the reason(s) and dates or grade (s):

Has the client ever been placed out of the home for mental health, emotional and/or behavioral reasons (foster care, inpatient treatment, residential treatment, juvenile detention, with relative, etc.): If yes, please explain:

Has anyone else in the family received psychiatric, psychological and/or chemical dependence treatment in an inpatient or outpatient setting? If yes, please explain:

What goal(s) do you have for the treatment of your child?

Miscellaneous:

What does your child like to do for fun (hobbies, interests, talents, etc.)?

What are your child's strengths?

What are your child's weaknesses?

Is there anything else I need to know to better help you and your family?
