Abella Counseling, LLC

Parent Questionnaire

Child's Information

Child's Name _____

Date of Birth _____ Age _____

Street _____City _____ State _____Zip _____

The child lives with ☐ Both Biological Parents ☐ Biological Mother ☐ Biological Father

☐ Step Parent ☐ Adoptive Parent ☐ Foster/Kinship Care ☐ Shelter

☐ Other (Specify) _____

Who has legal Custody of the child? *If parents are divorced and share custody both parents must give consent.*

_____

Parent/Guardian 1 Information

Name _____ Relationship _____

Date of Birth _____ Place of Birth _____

Street _____ City _____ State _____ Zip _____

Email _____

Phone (H) _____ (W) _____ (C) _____

Education/Occupation _____ Work Hours _____

Parent/Guardian 2 Information

Name _____ Relationship _____

Date of Birth _____ Place of Birth _____

Street _____ City _____ State _____Zip _____

Email _____

Phone (H) _____ (W) _____ (C) _____

Education/Occupation. _____ Work Hours _____

List all persons this child/adolescent is presently living with.

Name	Relationship	Age	School/Occupation

List other persons closely involved with your child who do not live in the home, and describe their roles.

_____

_____

_____

_____

Has your child experienced stressful or traumatic events? ☐ Yes ☐ No *If yes please describe the event(s) and approximate date(s).* _____

_____

_____

Academic Information

Name of school child is currently attending. _____Grade _____

Has your child ever been in special classes? *If yes please explain and provide dates.* _____

_____

Has your child ever repeated a grade? ☐ Yes ☐ No *If yes what grade?* _____

Does your child like school? _____

What type of student is your child? _____

How would you describe his/her study and homework habits? ☐ Good ☐ Average ☐ Poor

How often does your child read? ☐ Never ☐ Seldom ☐ Occasionally ☐ Often

Has your child ever had trouble in school with teachers, administrators, or peers? *If yes please explain.*

_____

_____

Describe concerns raised by daycare or school about your child's behavioral, peer interaction, and academic progress. _____

_____

_____

Was your child ever suspended or expelled from school? ☐ Yes ☐ No *If yes please explain.*

_____

Has your child ever been involved in a gang? _____

Other Information

What concerns about your child made you seek therapy at this time? _____

_____

_____

_____

Describe your child as an infant and toddler. List any complications at birth, delays in development, general difficulties, and signs of excessive worry, or fears. _____

_____

_____

_____

Describe any serious life stresses your child has experienced. Stressors can include placement away from home, physical or sexual abuse, neglect, domestic violence, divorce, chronic illness or injury.

_____

_____

_____

_____

List hospitalizations, and serious health issues like allergies, asthma or diabetes, include any head trauma your child has sustained. Also list any medications your child is taking. _____

_____

_____

_____

_____

Describe concerns related to your child's expression of anger. This may include tantrums, physical aggression towards family or peers, or self-harm. _____

_____

_____

Describe concerns related to daily routines. For example doesn't follow routines or stay on task, poor organizational skills. _____

_____

_____

Describe concerns related to peers. For example doesn't have many friends, very shy, gets teased, aggressive with peers.

Describe prior assessments and therapy your child has received. Please include the name of professional, dates, diagnosis, and nature of interventions. Describe what you found least helpful and most helpful about prior therapy.

What are your child's strengths, interests? List any after-school activities your child regularly attends.

Describe your relationship with your child. Describe your parenting strengths and weaknesses.

Who corrects the child? What methods are used? List some parenting strategies you find helpful.

What situations, people, or places make your child's anxiety worse? What makes your child's anxiety better?

How does your child typically deal with frightening situations? Some examples of reactions are avoiding the stressor, crying, yelling, clinging, or seeking reassurance.

How does your child's anxiety impact your family's day-to-day functioning? For example has your family routine changed to accommodate your child's anxiety?

Describe a time you responded in a way that reduced your child's anxiety. Include why your child was anxious and what you said and did.

Describe a time you felt you could have handled your child's anxiety better. Include why your child was anxious and what you said and did.

What would need to happen for you to feel like therapy was worthwhile?

Parent's Family History

Family Health History

Please indicate if you or anyone in your family has ever had any of the following:

	Condition	Relationship/Self	Comments
☐	Serious illness		
☐	Anxiety Disorder		
☐	Obsessive-Compulsive Disorder		
☐	Bipolar Disorder		

	Condition	Relationship/Self	Comments
☐	Depression		
☐	Learning Disability		
☐	Attention-Deficit Hyperactivity Disorder		
☐	Alcoholism/drug abuse		
☐	Other mental health concerns		
☐	Criminal convictions		

Have you been seen previously for assessment/counseling/marital counseling or are you currently in therapy? ☐ Yes ☐ No *If yes list name of the provider(s), date(s), place(s) of service, and reason for services.*

Please add any other information you feel is important.

Child/Adolescent Questionnaire

Your Wellness History

Why do you think you are here today? What were you told about this place?

Have you ever been in therapy before? ☐ Yes ☐ No ☐ I don't know. *If yes what that was like?*

Do you have to take medication every day? ☐ Yes ☐ No ☐ I don't know. *If yes what is it for?*

Do you take vitamins? ☐ Yes ☐ No ☐ I don't know.

Do you have allergies? ☐ Yes ☐ No ☐ I don't know.

Do you have asthma? ☐ Yes ☐ No ☐ I don't know. *If yes tell me about it.* _____

Do you feel sick a lot? ☐ Yes ☐ No ☐ I don't know. *If yes tell me about it.* _____

Do you feel like you get sick more than other kids? ☐ Yes ☐ No ☐ I don't know. *If yes tell me about it.*

Tell me about how do you feel most days. Some words you can use are angry, sad, worried, proud, happy, scared, bored, loved or unloved, shy, weird, or silly—or any other words about your feelings.

What do you like about yourself? _____

_____

_____

Is there anything you want to change about yourself? _____

_____

When you are angry who do you talk to? _____

What do you do when you are angry? _____

_____

When you are worried who do you talk to? _____

What do you do when you are worried? _____

_____

Have you ever felt so sad you wanted to kill yourself? ☐ Yes ☐ No

Did you have a plan? ☐ Yes ☐ No

Did you ever actually hurt yourself? ☐ Yes ☐ No Do you still think about that now? ☐ Yes ☐ No

Does anyone know about this? ☐ Yes ☐ No *If yes who?* _____

If you answered yes to any of these questions, please tell me more about it. Things like how long ago was it?

Do you still feel that way?_____

_____

_____

Is there anything else you'd like me to know.

_____

_____

_____

_____

_____