Strong Integrated Behavioral Health, LLC
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Provider:_____

PARENT QUESTIONNAIRE: INITIAL

Thank you for taking the time to complete your child/adolescent's intake form in its entirety. This will provide useful information to your provider in completing your intake session and planning your child/adolescent's evaluation and/or treatment.

Date:
Child's Name:
Child's Date of Birth:
Name of person completing form:
Relationship to Child:
Who suggested that your child be evaluated?

Child's Address:	
Child's School:	Grade Level:

Guardian 1 Name:	Guardian 2 Name:
Guardian 1 Relationship:	Guardian 2 Relationship:
Guardian 1 Address:	Guardian 2 Address:
Guardian 1 Phone #:	Guardian 2 Phone #:

Who lives with your child?		
Name:	Relationship:	Age:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

If parents of the child are separated or divorced:
1. Who has custody of the child?
2. What is the visitation schedule?

What concerns do you have about your child:
1.
2.
3.

Has your child experienced any traumatic events?
Has your child been physically or sexually abused?
Has your child been evaluated by Child Protective Services (CPS)?
Do you currently have a CPS caseworker? (Please give name)

Birth History		
Y	**N**	1. Are you the biological parent? (If no, please describe)
Y	**N**	2. Was your child a full-term pregnancy?
Y	**N**	3. If born before due date, how early?
Y	**N**	4. How was the baby born? Vaginal or C-Section
Y	**N**	5. Were there any complications during pregnancy?
Y	**N**	6. How much did the baby weigh at birth?
Y	**N**	7. Were drugs or alcohol used during pregnancy? (Please name)
Y	**N**	8. Were there any problems during labor/delivery or following birth? (Please describe)

Developmental History		
Y	**N**	Did your child sit up by 8 months?
Y	**N**	Did your child crawl by 10 months?
Y	**N**	Did your child walk by 15 months?
Y	**N**	Did your child speak single words or sentences by age 2?
Y	**N**	Did your child read simple words by age 6?
Y	**N**	Did your child cry frequently as an infant?
Y	**N**	Was your child difficult to calm down as an infant?
Y	**N**	Did your child have frequent temper tantrums as an infant/toddler?
Y	**N**	Did your child have colic as an infant?
Y	**N**	Was your child a picky or poor eater as an infant?
Y	**N**	Does your child have bowel/stool problems?
Y	**N**	Does your child have problems with bladder control (wetting)?
Y	**N**	Does your child have problems falling/staying asleep or waking up?
Y	**N**	Does your child have nightmares, night terrors, or sleepwalk?
Y	**N**	Has your child ever had tics/nervous twitches, or made noises/sounds?

Medical History		
Y	**N**	Has your child had major health problems? (Explain)
Y	**N**	Has your child been hospitalized? (Explain)
Y	**N**	Has your child had surgery? (Explain)
Y	**N**	Has your child had frequent ear infections?
Y	**N**	Has your child had vision or hearing problems?
Y	**N**	Has your child had a serious head injury or been unconscious? (Explain)
Y	**N**	Has your child had seizures or epilepsy?
Y	**N**	Has your child ever had problems with growth/weight/appetite?

		Family History of:	**Mother**	**Father**	**Other Relative (please specify)**
Y	**N**	Depression			
Y	**N**	Bipolar Disorder (Manic Depression)			
Y	**N**	Anxiety			
Y	**N**	Schizophrenia			
Y	**N**	Autism or Developmental Disorder			
Y	**N**	Tics or Tourette's Syndrome			

Y	**N**	Obsessive Compulsive Disorder (OCD)			
Y	**N**	ADHD/Hyperactivity			
Y	**N**	Substance or Alcohol Abuse			
Y	**N**	Learning Disability			
Y	**N**	Anorexia/Bulimia/Eating Disorder			
Y	**N**	Other emotional or mental problem (please specify)			

Mental Health History		
Y	**N**	Has your child ever seen a mental health therapist or counselor? (Give names and dates)
Y	**N**	Has your child ever been seen by a psychiatrist? (Give names and dates)
Y	**N**	Has your child ever been hospitalized for mental health treatments? (Give places and dates)
Y	**N**	Does your child have a history of suicidal behavior? (Describe)
Y	**N**	Does your child have a history of violence or aggression? (Describe)
Y	**N**	Does your child have a history of abusing drugs or alcohol? (Describe)
Y	**N**	Has your child been treated with medication for behavioral or mental health problems? (Give names of medications and doses)
Y	**N**	Is your child currently taking medication(s)? Name of medication Dose and time of day Reason for medication