Strong Integrated Behavioral Health, LLC
Phone: (541)393–5983 Fax: (541)393-5984

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?		
Date of Birth: _____ Preferred Language: _____. Nationality: _____ Racial/Ethnic: Asian/Pacific, African American, Hispanic/Latin, Native, Multi-ethnic, White American	Age: _____ Religion: _____	Gender Identity: Other: _____ Woman, Man, Transgender, Genderqueer Sexual Identity: Gay, Heterosexual, Lesbian, Bisexual, Pansexual, Queer, Other Pronouns:

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

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

Insurance Information: Primary
Insurance Company:_____ Phone:_____
Subscriber's Name:_____ Subscriber's DOB:_____
ID#_____ Group #_____

Relationship to Patient: Self_____ Spouse_____ Child_____ Parent_____ Other_____
Employer:_____

Insurance Information: Secondary
Insurance Company:_____ Phone:_____
Subscriber's Name:_____ Subscriber's DOB:_____
ID#_____ Group #_____
Relationship to Patient: Self_____ Spouse_____ Child_____ Parent_____ Other_____
Employer:_____

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)? <u>Name of medication</u> <u>Dose and time of day</u> <u>Reason for medication</u>