Balance & Potential Inc

Parent Questionnaire

(Confidential and Privileged Information)

If there are any questions you prefer not to answer, please just leave them blank. If you have any written reports or evaluations to share with us, you may bring them to your appointment.

I. PERSONAL DATA

Child's Name_____
(First) (Middle) (Last)

Name child prefers to be called_____

Date of Birth_____Present Age_____Gender Identity_____Ethnicity/Race_____

Person(s) filling out this form_____ Relationship to Child_____

Parent/Legal Guardian_____

❑Biological ❑Adoptive ❑Foster ❑Guardian ❑Primary Medical Decision Maker?:

Parent/Legal Guardian_____

❑Biological ❑Adoptive ❑Foster ❑Guardian ❑Primary Medical Decision Maker?:

Child's Address_____ County_____
(street) (apt. no.)

_____ Home Phone #_____
(city) (state) (zip code)

Other Address, if applicable_____ Whose?_____
(street) (apt. no.)

_____ Home Phone #_____
(city) (state) (zip code)

Mother's Cell Phone #_____ Mother's Email Address_____

Father's Cell Phone #_____ Father's Email Address_____

Alternate number_____ Whose?_____ Is this home, cell, or work?_____

Alternate number_____ Whose?_____ Is this home, cell, or work?_____

II. REFERRAL INFORMATION

Who referred you to Balance & Potential? (Name/Title)_____

Do we have permission to contact them? ❑ Yes ❑ No _____ Parent Signature & Date

III. PRESENT PROBLEM(S)/REASON FOR REFERRAL

Please describe in detail the current concerns (e.g., symptoms; how long, how intense)

_____

_____

_____

_____

_____

_____

What are some things that you might want help with for your family? Please describe what your family would like to gain from services. _____

_____

Current Symptom Checklist (Rate the intensity of symptoms that are currently present)**:**
0=This symptom is not present at this time
1=This symptom is present, somewhat bothersome, but not enough to be a problem
2=The symptom is present, bothersome, and affects quality of life, but child is able to function
3=This symptom makes moderate impact on quality of life and/or day-to-day functioning
4=This symptom makes significant impact on quality of life and day-to-day functioning
5=This symptom makes serious impact on quality of life and interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Alcohol problems		Stays out late/runs away		Sadness	
Drug problems		Absent from school		Low self-esteem	
Social/relational issues		Steals		Thoughts of death	
Academic problems		Inattentive		Thoughts of harming self	
Physically aggressive		Fidgets/squirms		Sleep problems	
Verbally aggressive		Fails to finish things		Poor appetite	
Bullies, threatens others		Difficulty playing quietly		Eats too much	
Loses temper easily		Talks excessively		Hears voices not there	
Argues with adults		Is forgetful		Sees things not there	
Defiant		Blurts out/interrupts		Anxious/fearful	
Annoys others on purpose		Loses things		Separation anxiety	
Easily annoyed by others		Poor organization skills		Physical complaints	
Angry/irritable		Easily distracted		Heart pounding/racing	
Destructive to property		Low energy/fatigue		Sexual behavior problems	
Lies (to avoid trouble)		Unpredictable moods		Cruel to animals	
Nightmares		Bedwetting		Following directions	
Problems bathing		Nervous habits		Fire setting	
Frequent illness		Other unusual behaviors:			

All children who have special needs or problems pose extra concerns for the family. What concerns you most about your child? _____

IV. MENTAL HEALTH HISTORY

Has your child ever been hospitalized for emotional difficulties? Please describe and include dates/length of stay.

Hospital, Program Type, City/State Dates & Length of Stay

Does your child currently have a mental health counselor/psychologist/social worker/psychotherapist? Yes or No

Please describe any outpatient mental health services your child or family has received from any psychologists, psychiatrists, counselors, social workers, mental health centers, other therapists, etc.:

Name & Agency, Type of provider, City/State Beginning When? & For How Long?

Any history of suicidal thoughts or attempts? ❑yes ❑no Please describe:

Any history of self-injurious behaviors (i.e., cutting, biting, hitting self)? ❑yes ❑no Please describe:

Please describe any family history of mental illness and/or alcohol/drug abuse:

V. MEDICAL HISTORY & MEDICATIONS

Who is your child's primary care physician (i.e., pediatrician or medical doctor)?

Name & Agency, Type of provider, City/State Month/Year of Last Annual Physical:_____

_____

Month/Year of Last Vision Checkup: _____ Normal?: _____

Month/Year of Last Hearing Checkup: _____ Normal?: _____

Other than Mental Health, does your child have any *current* Medical Diagnoses or physical or medical disabilities?

Please describe:: _____

_____

History of *Past* Major Medical Diagnoses, Disabilities, & Hospitalizations other than Mental Health:

_____

_____

List any medications for mental and/or physical health that the child is *currently* taking and the purpose for the medication.

Medication & Dosage	**Date Started**	**Prescribed by Whom? For what?**

Has any other medication ever been recommended for your child? Please explain.

_____

_____

VI. FAMILY/SOCIAL HISTORY

Mother's Full Name_____

Mother's Age at Birth of Child_____ Mother's Education_____

Mother's Occupation_____ Employer:_____

Father's Full Name_____

Father's Age at Birth of Child_____ Father's Education_____

Father's Occupation_____ Employer:_____

List all people who live or have lived in the child's home (including parents, other children, grandparents, stepparents, non-relatives, etc.) ✓Check Yes if Now in home.

Name	Age	Relationship	Quality of Relationship	Now in home?
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes
_____	_____	_____	❑Good ❑Fair ❑Poor	❑Yes

Marital Status of Parents:
Are the child's parents:

❑ Married ❑ Separated ❑ Divorced ❑ Not Married & Separated ❑ Not Married & Living Together

Who has legal custody of the child?_____

Who has healthcare decision-making rights of the child?_____

Please provide a copy of legal custody and medical decision-making documents.

Has either parent remarried?_____

Has any member of your immediate family experienced any of the following the past five years?
Please give approximate dates and describe.

❑ Death or serious illness of loved one ❑ Unemployment

❑ Change or promotion ❑ Surgery

❑ Family move ❑ Divorce

_____

_____

_____

_____

Social/Emotional:

Does your child usually play alone or with others?_____

_____

Please describe your child's interaction with others in your neighborhood:_____

_____

Does your child prefer being around adults or other children?_____

_____

Does your child belong to any school or outside groups (such as Scouts, religious groups, team sports, etc.)?

_____

_____

Please describe your child's chores and responsibilities in the home: _____

_____

How does your child express affection?_____

_____

How does your child express anger?_____

_____

How does your child handle stress?_____

_____

_____

How does your child relate to siblings and other children with whom s/he has contact?_____

_____

_____

_____

What are your child's interests and likes? What does your child spend time on and enjoy doing? _____

_____

_____

How would you describe your child's personality?_____

_____

_____

How would you describe your child's strengths?_____

_____

_____

What is he/she "good" at? _____

_____

What does he/she do well? _____

_____

VII. DEVELOPMENTAL HISTORY
Mother's Medical History during Pregnancy:

Total number of pregnancies_____ This child was the _____ pregnancy.
(number)

Did the child's mother have any complications during pregnancy (such as bleeding, emotional stress, illnesses, etc.)?

_____

Length of Pregnancy: ❑Full Term ❑Premature Child's Birth Weight_____

Were the parents and/or doctor concerned about the child's condition at birth?_____

_____

_____

Were there any complications or problems during your child's infancy or toddlerhood (such as feeding, sleeping or toileting problems, serious illnesses, high fevers, convulsions, etc.)?_____

_____

_____

_____

_____

Child's Developmental History:
Please record the age your child reached the following developmental milestones. If you cannot recall the age, check *early, normal, or late* to indicate when your child achieved each skill. Please use the provided age ranges as a guide.

Developmental Milestone	***Normal Age Range***	**EARLY**	**NORMAL**	**LATE**
Sat without support	*5-8 months*			
Crawled	*8-10 months*			
Stood without support	*9-12 months*			
Walked without assistance	*12-14 months*			
Spoke first words besides "ma-ma" & "da-da"	*7-12 months*			
Spoke in phrases	*1-2 years*			
Spoke in sentences	*2-3 years*			
Rode tricycle	*2-3 years*			
Bowel trained, day	*2½ -3 years*			
Bladder trained, day	*2½ -3 years*			
Bowel trained, night	*3-4 years*			
Bladder trained, night	*3-4 years*			
Buttoned clothing	*3-4 years*			
Named colors	*3-4 years*			
Said alphabet in order	*3-4 years*			
Tied shoelaces	*5-6 years*			
Began to read	*5-6 years*			
Rode bicycle without training wheels	*6-8 years*			

Does your child *currently* have any coordination problems (i.e.: throwing ball, kicking ball, coloring, cutting with scissors)?_____

_____

Did or does your child have any other problems with motor development (such as sitting, walking, running, handwriting, or other coordination.):

_____

_____

Please describe any problems or history of treatment with your child's speech:

:_____

_____

How does your child communicate? ❑ Gestures ❑ Words ❑ Sentences ❑ Crying

Has your child had any serious illnesses, injuries, bone fractures, operations, allergic reactions not yet described?

_____

_____

_____

VIII. EDUCATIONAL HISTORY

Current Grade _____ Ever Retained/Repeated a grade? ❑yes ❑no If yes, which grade_____

List the schools your child has attended (first school, to current school):

Please provide a copy of any current 504 Plan or Individualized Education Plan (I.E.P.), if applicable

School	Grade Levels	Dates	Special Ed. Services/504/IEP

How have teachers or other professionals described your child's problems?:

_____

_____

_____

Do the teachers' observations coincide with your own? ❑yes ❑no

IX. OCCUPATIONAL HISTORY

If applicable, please list any employment your child has/had (i.e., job title, employer, month/year started and ended, average # hours worked weekly):_____

_____

_____

X. LEGAL HISTORY

Please describe any history of legal involvement your child may have, including dates (e.g., pending claims, tickets, court involvement, juvenile workers, probation officers): ❑No Legal History

_____

_____

Thank you for your time. We look forward to meeting you!