Kids On Up Psychotherapy
101 Conner Drive, Suite 203
Chapel Hill, NC 27514

PARENT QUESTIONNAIRE

Date ____________________ Form Completed By ______________________________________

Child's Full Name ____________________________[ ]Male [ ]Female Birthdate___________

Address ____
Street City State County Zip

Guardian Name and Relationship________________________________ Birthdate _________
Address (*if different from above*) ____
Phones:
Home ________________ Can we leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N
Cell __________________ Can we leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N
Work _________________ Can we leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N
Email ___________________________________
Occupation, Employer____

Guardian Name and Relationship________________________________ Birthdate _________
Address (*if different from above*) ____
Phones:
Home ________________ Can we leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N
Cell __________________ Can we leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N
Work _________________ Can we leave a message w/a person? [ ]Y [ ]N Voicemail? [ ]Y [ ]N
Email ____________________________________
Occupation, Employer____

Insurance Information
Private Insurance company (e.g. BCBS, Cigna, etc)? [ ]Yes [ ]No
Please file on your own according to your out-of-network benefits
Public Insurance company (Medicaid, Medicare)? [ ]Yes [ ]No
If YES, Name of insurance company (list all): _______________________________________;
ID(s)# ______________________________ *Date issued:* _____________________

HEALTH INFORMATION

Pregnancy and Birth: Any complications? [ ]Yes [ ]No If yes, briefly explain:

____

____

Smoking during pregnancy [ ]Yes # cigarettes smokes per day _______ [ ]No

Alcohol consumption during pregnancy [ ]Yes # drinks per week ______ [ ]No

Other drug use during pregnancy [ ]Yes specify ___________________ [ ]No

Developmental Milestones Have you or your child's pediatrician had concerns regarding age he/she: Smiled ____ Sat without support: ____ Walked ____ First words ____Used sentences ____ Talked ____ Toilet trained at night ____ Toilet trained during day ____ Rode bike ____

Childhood diseases (age and complications if any)? [ ]Yes [ ]No If yes, briefly explain:

____

History of ear infections? [ ]Yes [ ]No If yes, briefly explain:

____

Allergies or asthma? [ ]Yes [ ]No If yes, please list:

____

Sleep problems, past and/or present? [ ]Yes [ ]No If yes, briefly explain: __________________

____

Hospitalizations? [ ]Yes [ ]No If yes, briefly explain:

____

Head injuries? [ ]Yes [ ]No If yes, briefly explain:

____

Name of Child's Primary Care Physician: ____

Child Last Physical Exam Date and Results:

____

____

Other relevant medical problems? ____

____

Is the child taking any medications? [ ]Yes [ ]No If yes, name of **Prescribing Doctor**:

____

Please list medications and describe any benefit or adverse effects from these medications:

____

____

____

____

Has the child received previous psychiatric treatment, psycho-educational testing, speech-language therapy, or occupational therapy?

[ ]Yes [ ]No If yes please list:

Dates	Name of Clinician	Reason for Treatment
___________	_______________________	____
___________	_______________________	____

Please do no write below this line

FAMILY INFORMATION

Parents' Marital Status ____________Date of separation/divorce, if applicable______/______

With whom does the child live? ____

Who has physical custody?______________________ Legal custody?____________________

Who generally disciplines the child? ____

What methods are used? ____

____

Do parents agree on methods of discipline? [ ]Yes [ ]No If no, please elaborate:

____

____

List all people living with the child in the home:

Name	Age	Relationship	Current Health	
________________________	_____	_________________	Good Fair Poor	____________________
________________________	_____	_________________	Good Fair Poor	____________________
________________________	_____	_________________	Good Fair Poor	____________________
________________________	_____	_________________	Good Fair Poor	____________________
________________________	_____	_________________	Good Fair Poor	____________________
________________________	_____	_________________	Good Fair Poor	____________________
________________________	_____	_________________	Good Fair Poor	____________________

Are any children adopted or with you in foster care?

[ ]Yes [ ]No If yes, please elaborate: ____

____

Please do not write below this line

FAMILY RECORD *Indicate with a check-mark the condition and relationship of any blood relative who has or has had any of the conditions listed below.*	None	Client	Parent	Parent	Grandfather	Grandmother	Brother	Sister	Other	Indicate Other Relative
Alcoholism/substance abuse										
Allergies										
Anxiety										
Attention Problems										
Autism/Developmental Problems										
Birth Defects										
Depression/Bipolar										
Diabetes										
Eating Disorder										
Learning Problems										
Major Mental Illness										
Migraines										
Obsessive-Compulsive Disorder										
Seizure Disorder										
Thyroid Problems										
Tic Disorder										
Other										

Has any other member of the child's immediate family had mental health treatment?

[ ]Yes [ ]No If yes, please elaborate: ____

____

____

Other Comments: ____

____

____

Please do not write below this line

SCHOOL INFORMATION

If your child has even been to a school (including nursery, kindergarten, grade school, and home school), complete the following for all grades beginning with nursery and ending with current placement. Please indicate if your child repeated or is in a special class (gifted/talented, learning disabled, behavior disordered, emotionally handicapped, etc).

Grade School Comments

_____ ________________________________ ________________________________

_____ ________________________________ ________________________________

_____ ________________________________ ________________________________

_____ ________________________________ ________________________________

_____ ________________________________ ________________________________

Has your child ever received special accommodations at school according to an Individual Education Plan (IEP) [ ] or 504 Plan [ ]? If check-marked, please list accommodations currently receiving: ________________________________

____

Has your child ever received academic tutoring? [ ]Yes [ ]No If yes, please elaborate:

____

____

CURRENT SCHOOL PERFORMANCE *Indicate with a check-mark the child's functioning for each academic subject.*	Failing	Below Average	Average	Above Average	Comments
Reading					
Writing					
Math					
Please list other academic subjects below (history, science, foreign language, etc)					

Please do not write below this line

SOCIAL INFORMATION

How many close friends does your child have? [ ]None [ ]1 [ ]2 or 3 [ ]4+

Does your child have a best friend? [ ]Yes [ ]No

Do you approve of your child's friends? [ ]Yes [ ]No

How many times per week does your child do things with friends outside of school?

[ ]None [ ]1 [ ]2-3 [ ]4+

Compared to other children of the same age, how does your child get along with other children?

[ ]Poor [ ]Average [ ]Great

Does your child prefer other children who are [ ]younger, [ ]older, or [ ] the same age?

Please list your child's favorite recreational or extracurricular activities and the approximate number of hour/week he or she spends doing them:

Activity

____ [ ]None [ ]1 [ ]2 or 3 [ ]4+

____ [ ]None [ ]1 [ ]2 or 3 [ ]4+

____ [ ]None [ ]1 [ ]2 or 3 [ ]4+

____ [ ]None [ ]1 [ ]2 or 3 [ ]4+

Please list any jobs or chores that your child has at home or at school, and how well he or she does these jobs. (For example, feeding the dog, making the bed, hall monitor, etc.)

[ ]None

____ [ ]Poor [ ]Average [ ]Great

____ [ ]Poor [ ]Average [ ]Great

____ [ ]Poor [ ]Average [ ]Great

What are your child's main strengths?

____

____

____

____

____

Please do not write below this line

PARENTAL CONCERNS

What do you believe is your child's main difficulty?

____

____

____

What do you believe caused this difficulty?

____

____

____

What have you been told by doctors, teachers and/or others about your child's difficulties?

____

____

____

Other Comments:

____

____

____

Please do not write below this line