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 Company_____

Please do not write below this line

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