COMPREHENSIVE COUNSELING CONNECTIONS, PLLC

Child and Adolescent Questionnaire for Parents

Patient

Patient's Name:_____ Date of Birth:_____
Home Address:_____

Reason for referral: _____
_____
_____

Family

Parents' names and dates of birth: _____
_____
Step-Parents (if any): _____
Parents' Place(s) of Employment (if any): _____
_____
Parents' highest level of education achieved: _____
Estimated annual household income: _____

Divorced or Legal Separation: ☐ *Yes* ☐ *No If yes, please share custody and visitation documentation. Note, we will need to receive authorization for testing of minors from both legal guardians. This will be explained further by your provider.*

Please comment on your parenting style as this child's parents (please include any other adult's significant to this child's upbringing i.e. grandparents, aunts, uncles, etc.): _____
_____
_____
List any problems that may contribute to difficulties you have parenting or managing your child:

Health: _____Physical: _____
Emotional: _____ Other: _____

Siblings/ages/grades:_____
_____
_____
Are any of the children in the family adopted? ☐ Yes ☐ No If yes, age(s) at time of adoption(s): _____

Are any family members diagnosed with a psychological illness or developmental delay? ☐ Yes ☐ No If yes, which family members and with what are they diagnosed? _____
_____

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Education

School: _____ Class/Year: t_____
Address: _____
_____
Phone Number: _____
Teacher's name: _____
Does your child have a 504 Accommodation Plan: ☐ Yes ☐ No
Does your child have an IEP: ☐ Yes ☐ No. What is his/her identified educational disability?_____
If your child has an active 504 Plan or IEP, please provide a copy of your child's to your provider.
Has your child repeated any grade?_____
If so, please explain: _____
_____
Is your child in special education? ☐ Yes ☐ No If so, for which class(es)?
_____

Physical Health
Current Health Concerns:_____
_____
_____
Child's Physician's Name: _____
Physician's Practice Name and Address: _____
_____
Physician's Phone Number: _____

Description of Concerns, please list areas of concern below:

Developmental Delays: _____
Problems with impulse Control: _____
Problems with attention: _____
Problems with activity level: _____
Problems with sleeping/eating: _____
Emotional problems:_____
_____
Other problems**:** _____

Patient's strengths, special talents, or special interests:

_____
_____
_____

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Prior assessments:

Speech and Language	Occupational Therapist	Psychologist
Date:	**Date:**	**Date:**
Outcome:	**Outcome:**	**Outcome:**
Pediatrician	**Hearing Test**	**Vision Test**
Date:	**Date:**	**Date:**
Outcome:	**Outcome:**	**Outcome:**

Any Additional Information: _____