ABIDING HOPE COUNSELING

Abiding Hope Child Questionnaire

Parents, please complete the following information regarding your child prior to your first appointment and bring it with you to the session. Completing this form in advance will help the assessment process go more quickly. During the initial session, we will review the provided information together. All information will be kept confidential.

Full Name:

Nick Name

Birth Date: **Today's Date:**

Parent's Names:

Address:

Phone Number:

Disclosure Statement signed? Yes or No

If applicable has the financial disclosure statement been signed?

Psychiatric & Medical History

Please list any psychiatric or "mental" problems your child has been diagnosed with: Please list any medical or "physical" problems that your child has been diagnosed with:

Please list any medications your child currently takes, and what they are taken for:

Name of Family doctor:

Phone:

Last check-up was during the month of **Year:**

Results:

Name of Psychiatrist **Phone:**

Last visit was during the month of: **Year:**

Results:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident	**Hospitalization**	**Surgery**	**Asthma**
A head injury	**High fever**	**Convulsions/seizures**	
Eye/ear problems	**Meningitis**	**Hearing problems**	
Allergies	**Loss of consciousness**		**Other**

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Does your child have any problems with vision, hearing, or dental health? Yes No (If yes, please describe.)

Are you aware of any sensory processing issues that your child has? Yes No (If yes, please describe.)

Has your child ever received speech therapy or occupational therapy? Yes No (If yes, please describe.)

Developmental History:

Term of pregnancy: months
Birth weight:
Were there any complications with the pregnancy or delivery? Yes No
(If yes, please describe.)

During pregnancy, was there any use of drugs/alcohol, exposure to domestic violence, major illnesses/accidents, or significant stressors? Yes No (If yes, please describe.)

<u>Age 0-3:</u>
Were there any delays in reaching major milestones, such as sitting up, crawling, walking, talking, and toilet training? Yes No (If yes, please describe.)

Were there any problems with feeding or sleeping? Yes No (If yes, please describe.)

What was your child's temperament and personality like as a child?

Please describe any significant stressors or events age 0-3:

<u>Age 4-6:</u>

Were there any concerns regarding developmental milestones? Yes No (If yes, please describe.)

How did your child adjust to beginning school?

How were your child's social relationships?

Please describe any significant stressors or events age 4-6:

<u>Age 7-12:</u>
Were there any concerns regarding development or social relationships?

Please describe any significant stressors age 7-12:

Family History & Relationships:

The name of the child's biological parents:

Who has legal guardianship of your child?

Who are other household members with your child and their relationship?

Ages of the other members?

Who are your child's significant others NOT living with your child? Such as friends, close relatives, etc.

Is there any history of CPS/Department of Child and Family Services involvement, including abuse/neglect reports, investigations, or removal of child from home? Yes No
(If yes, please describe.)

Has your child ever lived in another family situation (e.g., foster family, other caregivers, grandparent or kinship care, group home or residential placement)? Yes No

(If yes, please describe.)

Primary caregivers' relationship status:

- **Married**
- **Single**
- **Engaged**
- **Divorced**
- **Living together**
- **Partnered, living separate**
- **Separated**
- **Divorced**

- **Widowed**

Caregivers' occupations and education level:

Are there family members or others that you consider part of your family's support system? Please describe.

What do you consider to be your family strengths?

What do you feel that you need to improve or change as a family?

Family religious/spiritual identification:

Does your family actively participate in religion/spirituality? Yes No

Does your family consider religion/spirituality to be a source of support? Yes No
If yes, please describe:

Does your family actively participate in a religious community? If yes, how often?

If applicable: **Do you wish to incorporate your Christian faith in your child's counseling sessions?**

Do you have any concerns related to family relationships/interactions, parenting/discipline, or family communication? Yes No (If yes, please describe.)

What methods do you generally use for discipline of your children?

Please describe any past counseling that either your child or any family member

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? Yes or No if yes, please describe:

Education History:

What school does your child attend?

Address:

Phone: _____ Teacher's Name: _____
Current Grade: _____

What does your child's teacher say about him/her?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s)?

Does your child have an IEP or other special services at school? Yes No (If yes, please describe.)

Has your child been diagnosed with a learning disorder or other educational impairment? Yes No (If yes, please describe.)

Do you have any concerns about your child's behavior or academics at school? Yes No (If yes, please describe.)

Does your child participate in an afterschool program or other extracurricular activities? Yes No (If yes, please describe.)

Has your child experienced any of the following problems at School?

Fighting	**Lack of friends**	**Drug/Alcohol**	**Detention**
Suspension	**Learning Disabilities**	**Poor attendance**	**Poor grades**
Gang influence	**Incomplete homework**	**Behavior problems**	

Presenting Problem:

What are the main concerns that bring you to therapy?

How long has this been a concern?

How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe) Please describe:

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating) Please describe:

When did these problems start? What was going on in your child's life at that time?

What have you already tried to address the problem?

Has anything been helpful so far?

Has there anything that has not been helpful?

What do you hope to get from therapy and what are your goals for therapy?

Have you noticed any changes or problems with your child's sleep, appetite, or hygiene? (Please describe)

Has your child ever had psychotherapy or counseling before? Yes No (If yes, please describe.)

Has your child been given a previous psychological diagnosis? Yes No (If yes, please describe.)

Is your child currently taking any medications for emotional or behavioral reasons? Yes No If yes, please list name of medication, dosage, and reason prescribed.

Has your child taken any other medications in the past for emotional or behavioral reasons? Yes No

If yes, please list name of medication, dosage, and reason prescribed.

Has your child ever been hospitalized for emotional or behavioral concerns? Yes No If yes, please describe reason and provide name of hospital.

Has your child ever made suicidal statements, made suicide attempts, or self-harmed (including cutting)? Yes No (If yes, please describe.)

Do you have concerns that you child may be using drugs (including tobacco and marijuana or alcohol? Yes No (If yes, please describe.)

MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons? YES or NO

If yes, please describe when and where, and for which reasons.

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

CURRENT HABITS

Please describe how much time your child participates in each of the following areas per a week:
TV use:
Internet use:
Video game use:

Exercise:
Eating:
Sleeping:
Fun and relaxation:
Chores and responsibilities:

Behavioral Questions:

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

STRESSFUL LIFE EVENTS

Is there any history of trauma or upsetting life events? Please check those that are applicable and describe

A recent move or change in school
Abuse or neglect
Life threatening accidents
Medical concerns (self and/or in family)
Bullied or ignored by peers
Academic difficulties
Weight control issues
Sexual orientation concerns
Self-injury
Death or Illness of a loved one or pet
Family conflict
Separation or Divorce
Natural Disaster
Other

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another person?

If yes to either question above please describe the situation:

Has your child ever been exposed to pornography?

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Additional Information:

What are some of the strengths and positive qualities of your child?

What do you like about your child?

What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What concerns do you have about your child attending therapy or working on these problems?

Is there any other information that I should know regarding your child or family?

After you have completed all of the questions, save your document, and email it back at my secure and HIPPA-compliant email emoffitt.ah@pm.me

If you need to print it out and fill it out manually, then please bring it with you to your first session.

Thank you.

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