PARENT QUESTIONNAIRE:

Childs Full Name:____ Birth Date:____________
Parent completing this form: ______________________________________ Date: _______________

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.
____
____
____
____
____
____

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?
____
____
____
____
____
____

Other Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet.
____
____
____

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST?
____
____

What prompted you to seek out treatment NOW? ____
____

Who referred you or how did you hear about Dr. Dreke? ___________________________________

What discipline/punishment and/or reward techniques do you utilize most often (e.g., time-out, spanking, taking away privileges, yelling, sending to their room, opportunity to earn treats, etc.)

____

How effective are the strategies you are currently using? _____________________________

What rewards seem to motivate your child the most? ______________________________

____

Who is most often in charge of discipline? (e.g., mom, dad, or both parents equally?) _________

____

What does your child enjoy doing? (e.g.,hobbies, extracurriculars, favorite things to play/do) :

____

____

School History:

What school does your child attend?________________________________

Current Grade: _________________ Teacher's Name: ______________________________

Other schools attended (including Pre-school)

____

____

Are you happy with your child's school/teacher?______________________________

What are your child's current grades in school? _______________________________

____

Have your child's grades changed substantially in recent months (or since last school year)?

____

Do you struggle getting your child to do his/her homework? ______________________

____

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

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

____

____

____

____

Has your child ever received special education services/do they have an "IEP"? If so, please describe:

____

____

____

____

Has your child experienced any of the following problems at School? (circle all that apply)

fighting suspension	lack of friends	drug/alcohol	detention
gang influence	learning disabilities	poor attendance	declining or
OTHER:_________	incomplete homework	behavior problems	poor grades

Socially, does your child tend to be more of a leader or follower? _________________________
Does your child seem socially awkward at times (e.g., have difficulty joining in play, starting conversations with peers?) ____
____
Does your child express concern (or are you concerned) by them not having enough friends?
____
Is your child picked on/bullied by other children? ______________________________________
____

Medical History:

What is the name of your child's medical doctor? _______________________________________
Date of your child's last medical examination: __________________________________
Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? Y N If so, please list which ones:
____
____
____
Did the child's mother have any problems during the pregnancy or at delivery? Y N
If so, Please describe them:
____
____
____
____
Has your child experienced any significant medical problems?
____
____
____
____
Has your child experienced a serious accident? ____ head injury?____
If yes to either question, please describe:
____
____
____
Please list any medications your child takes on a regular basis:
____
____
____
Does your child wet or soil the bed? Y N (If yes, how often?_______________________________)
Does your child wet or soil him/herself during the day? Y N (if yes, how often?
____)
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? If yes to either question please describe the situation: ____

Family History:

Who lives in the home? **(Please include step-parents, significant others, extended family members, siblings, etc.)**

Name	Age	Relationship to Client

Who is involved in parenting this child/adolescent?

- ☐ **Two biological parents living in the same home?**
- ☐ **One biological parent?**
- ☐ **Biological parent & step-parent/partner/significant other?**
- ☐ **Biological parent & other relative (e.g., grandparent, aunt/uncle, etc.)**
- ☐ **Two adoptive parents living in the same home?**
- ☐ **Two biological parents living in different homes?**
  Shared custody/child splits time between living with ______________________ & ________________________________
  (Note: If client's parents are divorced, separated, and/or sharing custody, please describe how this arrangement impacts the child/adolescent's living situation (i.e., does he/she spend every weekends, holidays, summers, etc. with other parent?)
  ____
  ____
  ____
- ☐ **Other parenting situation: (please describe) ____**

Mother's history: age: ______
Occupation:____
Education (highest level completed):____
Learning or behavioral problems? (please specify): ____________________________________
Medical or emotional/mental health problems? (please specify):
____
____

Father's history: age: ______
Occupation:____
Education (highest level completed):____
Learning or behavioral problems? (please specify): _____________________________________
Medical or emotional/mental health problems? (please specify):
____
____

Biological parent(s)' history: If the above parents are not biological relatives, please include any medical/mental health/educational history you know about the child's biological parent(s):
____
____

Siblings' history: Please describe any learning, behavioral, emotional, or physical issues that any of your other children are currently experiencing or have experienced in the past:
____
____
____
____

Have there been any parental separations, divorce, custody changes, moves, deaths, illnesses, traumatic events, or other important family events?
____
____
____
____
____
____

Are there **current** family stressors? (e.g., parental fighting, sibling illness, financial stresses, etc.)
____
____

Please describe any past counseling that either your child or any family member has had:
____
____

Is there a history or current use of drugs by family members?
____