Family Counseling Center
Children's Questionnaire (to age 10)
For Parent/Guardian to Complete

Child's Name:_____ DOB:_____ Age:_____

School:_____ Grade:_____

Race/Ethnic Origin:_____ Religious Preference:_____

Family Members and Other Persons in Household

Name	Age	Relationship To Child	Grade Or Occupation	Living In Household?	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

If different from above, please give:
Biological mother's name:_____
Biological father's name:_____

Problem Description

Please state the problems for which you want help for this child:_____

_____

_____

_____

_____

_____

Previous mental health counseling and/or treatment:

Therapist/Program_____ Date:_____

Problem:_____

Therapist/Program_____ Date:_____

Problem:_____

Emotional/Behavioral/Chemical Issues

Has your child recently or currently experienced the following?

Yes	No		Yes	No	
___	___	Recent Suicidal thoughts	___	___	Difficulty sleeping
___	___	Suicide plans	___	___	Depression, loneliness, or hopelessness
___	___	Suicide attempts and/or self-inflicted injury	___	___	Crying often
			___	___	Frightening dreams or thoughts
___	___	A tendency to be shy or sensitive	___	___	Often annoyed by little things
			___	___	Difficulty completing tasks
___	___	A strong dislike of criticism	___	___	Violent or destructive behavior
___	___	A frequent loss of temper	___	___	Difficulty remembering
___	___	Difficulty expressing feelings	___	___	Difficulty concentrating
___	___	Nervousness, anxiety, or worry	___	___	Mental Confusion
___	___	Difficulty relaxing	___	___	Difficulty with eating
___	___	Difficulty making decisions			

Has your child ever been in court or picked up by the police? _____ Yes _____ No.

If yes, describe:_____

Do you think your child has tried cigarettes, sniffing, alcohol or drugs? ____ Yes ____ No

If yes, describe:_____

Child's Development

1. Were there any complications with the pregnancy or delivery of your child? ___ Yes ___ No ___

If yes, describe:_____

_____

2. Did your child have health problems at birth? _____ Yes _____ No

If yes, describe:_____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

___ Yes ___ No ___ Not sure If yes, describe:_____

_____

4. Did your child have any unusual behaviors or problems prior to age 3? ___ Yes ___ No ___ Not sure

If yes, describe:_____

5. Has your child experienced emotional, physical, or sexual abuse? ____ Yes ____ No ____ Not sure

If yes, describe:_____

Peer Relations

1. Is your child socially: ___outgoing ____shy ____depends on the situation.

2. Is your child involved in any organized social activities (e.g. sports, scouts, music)? _____

_____

3. What activities does your child prefer to do?_____

_____

4. Do you feel uncomfortable about any of your child's activities or toys? ____ Yes ____ No

If yes, please explain:_____

_____

School History

1. Has your child ever been held back a grade?_____

2. What are the grades your child receives at school?_____

3. Do you feel your child is doing the best he/she can at school?_____

4. Are there any behavior problems at school? ___ Yes ____ No

If yes, please explain:_____

_____

5. What is your child's best subject? _____

Worst subject?_____

6. How many schools has your child attended?_____

Discipline

1. How do you discipline your child? Describe:

Father:_____

Mother:_____

Other adults in family:_____

2. Are there differences between father and mother with regard to discipline? ____ Yes ____ No

If yes, please explain:_____

_____

Have these differences been a source of strain in the family? ____ Yes ____ No

3. Who usually disciplines the child?_____

4. Does the child prefer one parent over the other? ____ Yes ____ No

If yes, whom?_____

Medical History

Check the age(s) at which this child had any of the following health problems. If the child has never had the problem, check the box in the "Never" column. If the health problem is still continuing or is a current concern, check the box in the "Current Concern" column. More than one category may be checked.

	Never	O-6 Months	7-12 Months	1-2 Years	2-4 Years	4-6 Years	Since 6 Years	Current Concern
High fever (over 103°)								
Seizures (convulsions)								
Rashes or skin problems								
Meningitis								
Asthma								
Food allergies								
Other allergies								
Pneumonia								
Anemia (low blood count)								
Heart problems								
Kidney or urinary problems								
Bowel problems								
Trouble with vision								
Trouble with hearing								
Lack of weight gain								
Poisoning or medication overdose								
Serious injury								
Hospitalization								
Surgery								

Other important illnesses (list):_____

_____

Medication used over a long period of time (list):_____

_____

Current medication:_____

In general, this child's heath has been:

_____ excellent (is rarely sick, when sick recovers very quickly)
_____ good (is not often sick or injured, illnesses are fairly short-lived)
_____ fair (frequently sick or injured, illnesses often linger or recur)
_____ poor (chronically ill)

Name of physician:_____

Child's Strengths

Please mark those strengths that you have observed in your child:

	Often True	Sometimes True	Seldom True	Cannot Say
Outgoing				
Self-confident				
Seems happy				
Friendly				
Enjoys new experiences or activities				
Even disposition or steady moods				
Expresses feelings				
Affectionate				
Kind or sympathetic to others				
Shares				
Can compromise				
Follows rules easily				
Is forgiving				
Stands up for self when appropriate				
Tolerates criticism				
Recovers easily after disappointment				
Is appropriately cautious				
Creative				
Plays gently with smaller children or animals				
Good sense of humor				

Family Illnesses/Disorders

	Mother's Family	Biological Mother	Biological Father	Father's Family
Anxiety disorders				
ADHD or ADD				
Mental retardation				
Seizure disorder				
Depression				
Schizophrenia				
Other psychiatric disorder				
Learning difficulties				
Behavioral problems				
Alcoholism or drug dependence				

Inherited conditions (e.g. Huntington's Chorea, Sickle Cell Anemia): _____

_____

Other significant family illness: _____

_____

Parent's History

Biological Father:
Birth date: _____
Ethnic origin: _____ Occupation: _____
Place of Employment: _____
Date of marriage: _____ If separated, divorced, widowed, previously married, please specify and give dates: _____

_____

Education (Check appropriate categories and specify year and degree reached in each category):

Elementary	High School	Technical Training	College	Graduate School	Other (Specify)
_____	_____	_____	_____	_____	_____

Biological Mother:
Birth date: _____
Ethnic origin: _____ Occupation: _____
Place of Employment: _____
Date of marriage: _____ If separated, divorced, widowed, previously married, please specify and give dates: _____

_____

Education (Check appropriate categories and specify year and degree reached in each category):

Elementary	High School	Technical Training	College	Graduate School	Other (Specify)
_____	_____	_____	_____	_____	_____

Parent's Marital/Significant Other Relationship

1. Would you describe your present marital/significant other relationship as (check one):

_____ smooth

_____ with occasional difficulties

_____ with frequent difficulties

_____ failure

2. Describe any significant relationship problems now, or in the past:_____

_____

_____

_____

_____

3. Have you sought outside help with regards to relationship problems? ____ Yes ____ No

If yes, please give details:_____

_____

_____

_____

4. Does any parent/caregiver have difficulties with nervousness, anxiety, or depression? ____ Yes ____ No

If yes, please explain:_____

_____

_____

5. Does any parent/caregiver have difficulties with anger, e.g. losing temper easily, verbally abusive, being violent when angry? ____ Yes ____ No If yes, please explain:_____

_____

_____