

A NEW START COUNSELING CENTER, INC.

PARENT/LEGAL GUARDIAN QUESTIONNAIRE (AGE 5-12)

TO BE COMPLETED BY PARENT/GUARDIAN REQUESTING SERVICES FOR A MINOR CHILD

This information will help your therapist understand your child. This, as well as other communications with your therapist, will be kept confidential to the full extent of Georgia Law.

BACKGROUND INFORMATION

Today's Date: _____

Name of Child _____ Date of Birth _____ Age _____

Parent's Name (s) _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Work _____ Other _____

Referred by: _____

Address of Referral Source (if known) _____

May we mail a thank you letter to your referral source? _____

BILLING INFORMATION

Person responsible for bill _____

Relationship to Client _____

INSURANCE INFORMATION

PRIMARY

SECONDARY

INSURANCE COMPANY _____

INSURED'S NAME _____

EMPLOYER _____

RELATIONSHIP TO CLIENT _____

INSURED'S SOCIAL SECURITY NO: _____

FAMILY

NAME

AGE

FATHER _____

MOTHER _____

OTHERS LIVING _____

IN HOME _____

In your own words, briefly describe the main problem which prompted you to seek counseling for your child at this time.

Problem Areas: In the following list, place a check mark next to each item which identifies as area of concern to you. Place two checks by those items which are most important.

- | | |
|---|---|
| <input type="checkbox"/> Anger/Temper | <input type="checkbox"/> Religious/Spiritual Concerns |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Concerns |
| <input type="checkbox"/> Education/School Work | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Family Problems/Fighting with
Brothers & sisters | <input type="checkbox"/> Unhappy most of the time. |
| <input type="checkbox"/> Fearfulness/Phobias | <input type="checkbox"/> Use of Alcohol |
| <input type="checkbox"/> Insecure/Timid/Lack of Self Confidence | <input type="checkbox"/> Use of Drugs |
| <input type="checkbox"/> Marital Problems/Conflicts
between parents, Divorce | <input type="checkbox"/> Work |
| <input type="checkbox"/> Problems with accepting discipline | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Problems in relationships with other Children | <input type="checkbox"/> Physical Problems |
| <input type="checkbox"/> Other (Specify) | <input type="checkbox"/> Traumatic Stress |
| | <input type="checkbox"/> Stress |

Has your child ever been the victim of or witnessed any type of traumatic incident? If yes, please explain:

MEDICAL HISTORY

List sicknesses, operations and injuries. Indicate age when occurred and describe how severe.

Has there been any previous counseling or psychological, psychiatric, neurological, or E.E.G. evaluations? _____ If so, please list names, addresses and dates of contact.

Indicate any continuing medication treatment

How is the child's vision? _____

How is the child's hearing? _____

Describe previous speech or hearing therapy, if any _____

When did the child last have a physical examination ? _____

Name of Physician _____

Address _____

DEVELOPMENTAL INFORMATION

Age sat by self? _____ Age walked alone? _____ Age said first word? _____

Age talked in sentences? _____ Age gave up bottle during the day? _____ Night? _____

Age gave up day napping? _____ Age toilet trained? _____

Urine day _____ (easy _____ difficult _____)

Night _____ (easy _____ difficult _____)

Bowels day _____ (easy _____ difficult _____)

Night _____ (easy _____ difficult _____)

Infant feeding habits-Breast fed? _____ How long? _____

Describe child's appetite and eating habits at present. _____

Describe nervous habits such as thumb sucking, nail biting, etc. _____

Describe child's sleeping pattern now. Are there nightmares or night terrors now or in the past?

Describe child's level of activity and vigor: _____

Describe any method of discipline and how the child reacts to such discipline? Any stubbornness?

Describe any moody periods: _____

Describe any problems with awkwardness or clumsiness: _____

How does the child get along with other children in the family? _____

How does the child get along with children not in the family? A leader? Follower? Playing with children who are older? Younger? _____

Describe any difficulty pronouncing words or speaking: _____

Describe any difficulties in learning or understanding at home: _____

ACADEMIC/SCHOOL INFORMATION

Name of school _____ Grade _____ Teacher _____

List previous schools attended with dates: _____

Has child ever repeated a grade? _____ If so, when? _____

How does the child get along at school? _____

Describe difficulties in learning at school _____

Have other family members had learning difficulties? _____

Describe what the child likes to do for fun, special interest, hobbies, etc.

We very much appreciate your cooperation in filling out this questionnaire. Please add any additional comments which you wish to tell your therapist. _____

I declare that I am the custodial parent or legal guardian of the child described in the document and that I have the legal authority to bring him or her for psychological treatment.

SIGNED: _____

DATE: _____