

**A NEW START COUNSELING CENTER, INC.**

**PARENT/LEGAL GUARDIAN QUESTIONNAIRE (AGES 13-17)**

**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.

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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                 | <input type="checkbox"/> Unhappy most of the time.    |
| Brothers & sisters   | <input type="checkbox"/> Use of Alcohol               |
| <input type="checkbox"/> Fearfulness/Phobias                           | <input type="checkbox"/> Use of Drugs                 |
| <input type="checkbox"/> Insecure/Timid/Lack of Self Confidence        | <input type="checkbox"/> Work                         |
| <input type="checkbox"/> Marital Problems/Conflicts                    | <input type="checkbox"/> Worry                        |
| between parents, Divorce   | <input type="checkbox"/> Physical Problems            |
| <input type="checkbox"/> Problems with accepting discipline            | <input type="checkbox"/> Traumatic Stress             |
| <input type="checkbox"/> Problems in relationships with other Children | <input type="checkbox"/> Stress                       |
| <input type="checkbox"/> Other (Specify)                               |   |

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

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**MEDICAL HISTORY**

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

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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.

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Indicate any continuing medication treatment

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When did the child last have a physical examination? \_\_\_\_\_

Name of Physician \_\_\_\_\_

Address \_\_\_\_\_

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

\_\_\_\_\_

Describe any moody periods: \_\_\_\_\_

**ACADEMIC/SCHOOL INFORMATION**

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

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? \_\_\_\_\_

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: \_\_\_\_\_