CEDAR CREEK ASSOCIATES

…private, independent practitioners

PARENT OF ADOLESCENT QUESTIONNAIRE

Personal and Family Information

Name of adolescent _____ Date _____

Date of Birth _____ Mother's occupation _____

Father's occupation _____ Religion _____

Approximate family income _____

If your child was adopted, please answer the following questions:

At what age was the child adopted? _____ Does the child know he or she is adopted? _____

If yes, at what age was the child told? _____ Has your child had any contact with the biological parent(s) since the adoption? _____ If so, please describe _____

Does the child mention the biological parents? _____

Please list people living in the home (include parents, siblings, anyone living in the home):

Name	Age	Relationship to child

Please list other immediate family members <u>not</u> living in the child's home:

Name	Age	Relationship to child

Are you or your spouse a stepparent? _____ If so, how old was the child when he or she began living with the stepparent? _____ How would you characterize the stepparent's relationship with the child? _____ Excellent _____ Good _____ Average _____ Poor _____ Bad

How would you characterize the child's relationship with others in the home:

Name	Relationship to child	Quality of relationship

Educational Information

School _____ Grade _____ Has your child ever failed a grade or been held back: _____ If so, please describe the circumstances _____

_____ What kinds of grades does the child earn? _____

Has your child ever received special education programming? _____ If so, please describe:

_____

Has your child ever won any honors or been placed on the honor roll? _____

List current school activities _____

Please describe your child's school adjustment

_____

Health Information

Date of last physical exam _____ Physician _____

Please list any illness or medical conditions _____

Please list all medications and state the purpose for each

_____

Please list allergies (include allergies to medicine) _____

Do you (or does your child) have any concern about the child's weight or diet? _____

If so, please explain _____

Has your child ever been unconscious from a head injury? _____ If so, please explain and include the date of the injury _____

Has you child ever been abused sexually or physically, neglected, the victim of a crime, or otherwise traumatized? _____ If so, please explain _____

To your knowledge, does your child use (or has he/she tried):

Alcohol	_____	Barbiturates	_____	Cocaine	_____
Crack	_____	Heroin	_____	Inhalants	_____
LSD	_____	Marijuana	_____	Opiates	_____
PCP	_____	Other	_____		

Has any other member of the family had a drug or alcohol problem now or in the past? _____

If so, please indicate who, the substance used, and whether the problem is ongoing:

Has any member of the child's immediate or extended biological family ever had a nervous or mental disorder? _____ If so, please state the person's relationship to the child and the nature of the problem _____

Has your child ever received counseling before or had an evaluation? _____ If so, please name the provider and give dates _____

Social and Recreational Information

Please list your child's hobbies and interests: _____

Does your child have friend his or her age? _____ How would your describe your child's relationships with peers? _____

Does your child have a best friend? _____ Does he or she have a girl/boyfriend? _____

Does your child have any particular friends of whom you do not approve? _____ If so, please explain _____

Which of your child's activities do you and/or your spouse regularly attend? _____

Has your family taken a vacation together with this child? _____ When/where? _____

Please describe any past or present legal problems of situations that involved your child:

_____

_____

Presenting Problem

Please state the reason you are seeking treatment for your child _____

_____

How sever is/are the problem(s) to you?

1	2	3	4	5
Mildly upsetting		Severe		Totally incapacitating

How sever is/are the problem(s) to your child?

1	2	3	4	5
Mildly upsetting		Severe		Totally incapacitating

When did the problem(s) begin? _____

What have you or your child tried to do to solve the problem? _____

_____

Which areas in your child's life do these problems affect?

School performance	_____	Self esteem	_____	Friendships	_____
Family relationships	_____	Daily activities	_____	School activities	_____
Other	_____				

Please check any symptoms your child is experiencing:

Tiredness	_____	Difficulty sleeping	_____	Crying	_____
Argues a lot	_____	Sadness	_____	Nervousness	_____
Loss of interest in activities	_____	Irritability	_____	Mood swings	_____
Withdrawal from others	_____	Changed eating habits	_____	Depression	_____
Misses school	_____	Overly active	_____	Destructive	_____
Hurts self or talks about it	_____	Sleeps too much	_____	Too aggressive	_____
Too passive	_____	Worries a lot	_____	Nightmares	_____
Grades dropped	_____	Won't cooperate	_____	Strange ideas	_____
Won't obey	_____	Suicide attempt	_____	Other	_____

Please check any recent changes your child has experienced:

New school or new grade of school	_____	Illness, injury, or recovery	_____
Child moved into or away from home	_____	Family moved	_____
Parents separated ore divorced	_____	Sibling left home	_____

Please check any recent changes your child has experienced (cont.):

Loved one died _____ Grades changed _____
New family member _____ Legal trouble _____
School trouble _____ Any violence _____

Other major loss _____ Other _____

Media Information

Does you child have a TV in his or her room? _____ Yes _____ No

About how many hors a week does your child watch TV? _____

Does he/she choose the programs he/she watches? _____ Yes _____ No _____ Some

About how many hours a week does your child play video games? _____

What are some of the video games he/she plays?

_____

Does your child get your permission before seeing a movie? _____ Yes _____ No

Which ratings of movies is your child allowed to see?

_____ G _____ PG _____ PG-13 _____ NC-17 _____ R

Does your child have access to the internet at home? _____ Yes _____ No

If so, please describe any restrictions to accessing the internet: _____

_____

_____

I certify that I have (check one):

_____ **Custody of this child**
_____ **Managing conservatorship of this child**
_____ **Possessory conservatorship of this child**
_____ **Joint custody or joint managing conservatorship with** _____
_____ **Legal guardianship**
_____ **Other: please describe** _____

_____ _____
Signature of parent or guardian **Date**

I give permission to _____ to treat my child _____

in psychotherapy. I am the custodial parent or legal guardian of the child and I have the legal

authority to authorize treatment.

_____ Without the consent of anyone else.

_____ Only with the consent of

_____

Name

_____

Address (number and street)

_____

City, State, and Zip Code

_____

Phone Number

_____ I agree to provide any necessary documentation.

I understand that no child custody evaluation will be performed and that therefore my therapist will not formulate an opinion regarding any custody issues, and that requiring the therapist to testify regarding custody issues would be harmful to my child and the therapeutic relationship.

_____ _____

Printed name of parent or guardian **Relationship to child**

_____ _____

Signature of parent or guardian **Date**

Thank you for selecting me as your child's therapist. Please feel free to discuss any concerns you may have about your child's treatment. At any time that I am alone with your child, you are invited to open the door and check on your child's well-being. The ending of therapy is as important to children as what takes place within it and I request that you talk with me about how therapy will terminate before we actually end.

MEDICATION LISTS & MEDICAL ALLERGIES

Patient Name: _____ Date: _____

No Medications: _____ List Allergies to Medications: _____

Medications currently taking: _____

	Dosage	Frequency	Date Began
Antidepressants:			
Celexa (Citalopram)			
Paxil (Paroxetine hydrochloride)			
Prozac (Flouxetine hydrochloride)			
Serzone (Nefazodone hydrochloride)			
Zoloft (Setraline)			
Anti-anxiety:			
Ativan (Lorazepam)			
Klonopin (Clonzaepam)			
Valium (Diazepam)			
Xanax (Alprazolam)			
Hypypnotic:			
Elavil (Amitriptyline hydrochloride)			
Remeron (Mirtazapine)			
Tofranil (Imipramine)			
ADHD:			
Adderall (Amphetamines)			
Cylert (Pemoline)			
Dexedrine (dextroamphetamine sulfate)			
Ritalin (Methyphenidate hydrochloride)			
Mood Stabilizer:			
Depakote (Valproic Acid)			
Haldol (Halperidol)			
Lithonate (Eskalith, Lithobid)			
Respirdal (Respiradone)			
Tegretol (Carbamazepine)			
Zyprexa (Olanzapine)			
Sleeping Medications:			
Ambien (Zolpidem)			
Trazadone (Desyrel)			
Other _____			
Other _____			
Other _____			

_____ _____

Signature Date