Parent of Teen Questionnaire

Name of parent/guardian completing form:_____

Name of teen_____

Who referred you to us?_____

Previous counseling (names and dates)_____

_____

What are some examples of your teen's behavior which you are concerned about?____

_____

_____

How long have you had these concerns (include a brief history of the problem)?

_____

_____

To what degree does the problem affect your family life?

Mild Moderate Significant Severe

To what degree does the problem affect your teen's functioning at school? With peers?

Mild Moderate Significant Severe

Check any behavior(s) that apply to your teen:

- ☐ Anxiety, nervousness
- ☐ Argues, talks back, defiant
- ☐ Bullies/intimidates, teases
- ☐ Is bossy to others, picks on, provokes
- ☐ Low frustration tolerance
- ☐ Moody
- ☐ Nervous
- ☐ Nightmares
- ☐ Overactive, restless
- ☐ Oppositional, resists, refuses
- ☐ Disobedient, uncooperative
- ☐ Drug or alcohol use
- ☐ Eating---appetite increase or decrease
- ☐ Suicide talk or attempt
- ☐ School suspension
- ☐ Legal difficulties
- ☐ Likes to be alone, withdraws
- ☐ Lying
- ☐ Concern for others
- ☐ Conflicts with friends
- ☐ Conflicts with parents over rules
- ☐ Difficulties with school
- ☐ Cries easily, feelings are easily hurt
- ☐ Dependent, immature
- ☐ Disrupts family activities
- ☐ Distractible, inattentive
- ☐ Sad, unhappy
- ☐ Self-harming behaviors
- ☐ Hostile, destructive

Please check if your teen has experienced any of the following:

☐ dental problems	☐ hair/scalp problems	☐ severe headaches
☐ skin problems	☐ high blood pressure	☐ vision problems
☐ diarrhea	☐ accidents/broken bones	☐ constipation
☐ insomnia	☐ stomach problems	☐ allergies
☐ dizziness/fainting	☐ tiredness	☐ overeating/undereating
☐ nervous habits	☐ seizures	☐ sleep problems
☐ diabetes	☐ attention problems	☐ other medical issues

If any of the above are checked, please provide more information:_____

_____

_____

Is your teen presently under a physician's care for any of the above? **Yes** **No**

Is your teen presently on any medication? **Yes** **No** If yes, what is it and dosage?___

_____

Date of teen's last physical exam:_____

Teen's Primary Care Physician_____Phone:_____

Has your teen been in any difficulty with the law? If yes, please describe:_____

_____

Has your teen ever spoken of suicidal thoughts at any time in the recent past or present? Or has your teen ever made a suicidal gesture? If yes to either, please explain:_____

_____

Describe any concerns you have about school and/or school performance: _____

_____

Is your teen in any behavioral or non-traditional programs at school?_____

_____

Does your teen participate in any after school or extracurricular activities?_____

_____

Describe any special circumstances the therapist should know about:_____

_____

_____

What are your goals for your teen for counseling?_____

_____

_____

_____

FAMILY INFORMATION

With whom does your teen live with?_____

_____

If divorced, what are custody and visitation arrangements? _____

_____

_____

If divorced, what is the relationship between the parents like now?_____

_____

_____

What is the father's relationship with your teen like?_____

_____

Mother's?_____

_____

Describe parents' method of discipline. Do parents agree or disagree? How does it seem to work?_____

_____

_____

Please check any of the following which apply to your family (extended family included). Please indicate to whom a problem applies (i.e.: maternal grandmother, father, etc.):

☐ depression	☐ anxiety	☐ bi-polar disorder (manic/dep)
☐ schizophrenia	☐ attention deficit	☐ obsessive-compulsive
☐ sexual abuse	☐ physical abuse	☐ chemical dependency
☐ learning disabilities	☐ suicide	☐ other:_____

_____

_____

MEDICAL HISTORY/HOSPITALIZATIONS

Serious illnesses:_____

Serious injuries:_____

Hospitalizations:_____

Does anyone in your family, including grandparents have a history of alcohol/drug use or mental illness? Who? _____

_____