CLINTON COUNSELING CENTER
PARENT SOCIAL MEDICAL QUESTIONNAIRE

Please respond to ALL questions/information. There are multiple two sided pages. Check to be sure you have completed them all. **Fill this out for/about your child** who will be seen for counseling.

Identifying Data:

Name: ____ Birth Date:____/____/____ Age:_______ Sex________

Address: ____
(Street) (City) (State) (Zip Code)

Phone Numbers: Home: (_____)-______-______ Emergency Contact: (_____)-_____-_______

What prompted you to seek assistance at this time for your child: ____

____

How long has this situation been a problem or concern for you or your child? ____________________________________

How did you hear about Clinton Counseling Center? ____

Have you or your child ever been to Clinton Counseling Center before for any reason? [ ] Yes [ ] No [ ] Unsure

If so, when? ____

Race: [ ] Caucasian [ ] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other: ______________________

Is there **ANY CHANCE** that your child is currently pregnant? [ ] Yes [ ] No [ ] Unsure [ ] N/A

Family/Cultural Information:

Birth Place: ______________________________________ Place Raised: ______________________________________

Who is raising your child? ____________________________ Number of people in your child's family:_________

Number of Brothers: _______ Number of Sisters:_______

Parents Current Marital Status: _________________ If parent (s) deceased, how old was child at the time? __________

If parents divorced, how old was child at the time: ______ Who raised child after the divorce? _______________________

Father's age now_______ Father's Occupation: ____________________ Father's age at death: ________

Mother's age now ______ Mother's Occupation: ____________________ Mother's age at death: ________

Describe your perception of child's current relationship with:

Father: ____

Mother: ____

Brothers & Sisters: ____

Has your child ever run away from home? [ ] Yes [ ] No

Does your child follow house rules? [ ] Yes [ ] No

To your knowledge, has your child ever been: [ ] Sexually Abused [ ] Physically Abused [ ] Emotionally Abused

By whom? ____

Age when abused: _______________ Duration of Abuse: ___________________

Describe briefly what happened: ____

____

Educational History:

Highest level of achievement:

[ ] Still in school: What grade is your child in: _______ What school does your child attend? _______________________

[ ] Dropped out of school - Reason: ______________________________ What was highest grade completed? ________

Does your child like school? [ ] Yes [ ] No What led you to believe this? __________________________________

____

State any educational concerns: ____

Religious/Spiritual Background:

Your child is involved with a religion: [ ] Regularly [ ] Irregularly [ ] Never

What is your current religious preference: ____

Vocational Background:

Is your child currently employed? [ ] Yes [ ] No If employed, length of employment at present job: ____________

Job Title/Position: ______________________ Do you believe that they are satisfied with their work? _______________

Job History: Type Work	Length of employment	Reason for leaving	Degree of Satisfaction
_________________________	_________________	______________	________________________
_________________________	_________________	______________	________________________

If you experience any concerns about your child's employment, please state them: ________________________________

____

Social/Relationship Background:

With whom does your child spend <u>MOST</u> of their time: [ ] Family [ ] Friends [ ] Acquaintances [ ] Alone

How often does your child see friends/acquaintances: [ ] Daily [ ] Frequently [ ] Occasionally [ ] Rarely [ ] Never

Do you approve of your child's friends and activities? [ ] Yes [ ] No

If no, what are your concerns? ____

____

Is or has your child been involved in a serious relationship that may include sexual activity? [ ] Yes [ ] No [ ] Unsure

Are you concerned about any intimate relationships that your child has had or is having? [ ] Yes [ ] No [ ] Unsure

If so, please state your concerns: ____

To your knowledge, has your child had any pregnancies or gotten any person pregnant? [ ] Yes [ ] No

If so, what was the outcome? ____

To your knowledge, has your child been involved in any gang activity? [ ] Yes [ ] No

Leisure Time/Interests:

List any hobbies, interests, or social talents that your child has: ____

Do they participate in their hobbies etc? [ ] Regularly [ ] Sometimes [ ] Irregularly [ ] Rarely [ ] Never

Has their use of leisure time changed in the past year? [ ] Yes [ ] No

If yes to above question, describe changes: ____

____

Describe what you believe to be a typical day for your child: ____

____

Financial Factors:

Do you currently have financial problems? [ ] Yes [ ] No

Are your problems? [ ] Very serious [ ] Serious [ ] Not to serious [ ] Can handle them

Describe the nature of your financial problems: ____

How (if at all) do you feel these financial factors impact your child? ____________________________________

Legal Status:

Your child is currently: [ ] On probation [ ] Awaiting charges [ ] Awaiting trial/Sentence [ ] No police involvement

How many times has your child been arrested or ticketed for anything? _______________

Charges	Date	Outcome	Alcohol/Drug Related	
________________________	_______	____________________	[ ] Yes	[ ] No
________________________	_______	____________________	[ ] Yes	[ ] No
________________________	_______	____________________	[ ] Yes	[ ] No
________________________	_______	____________________	[ ] Yes	[ ] No

Has your child ever been in the Youth Home/Detention Center? [ ] Yes [ ] No
Have you or your child ever been involved with protective services? [ ] Yes [ ] No

If yes, please describe circumstances ____

Medical/Health History:

Do you have a routine health care provider (non-emergency room) for your child? [ ] Yes [ ] No

If so, please provide the doctor/practice name and city where the office is located:

____

Has your child had a physical exam in the last two years? [ ] Yes [ ] No

Has your child been immunized? [ ] Yes [ ] No

Does your child have any current medical complaints or recurring physical symptoms/pain that they are not receiving medical attention for? [ ] Yes [ ] No

Does your child have any current physical impairments or disabilities that they are not receiving medical attention for? [ ] Yes [ ] No

Does your child have Blue Cross/Blue Shield health insurance? [ ] Yes [ ] No

Hospitalizations/Surgery in last 5 years:

Problems	Year/Age	Outcome

Major Illness in last 5 years:

Problems	Year/Age	Outcome

Any previous Mental Health treatment:

Problems	Year/Age	Outcome

Any current medications that your child is taking for any reason:

Type/Name/Dosage	Why do they take it?	Who prescribes this for them?

Any Accidents/Injuries in the last 12 months:

Type	Year/Age	Outcome

Have you noticed that your child has been: [ ] Sleeping too much [ ] Not sleeping enough
[ ] Getting the right amount of sleep

Have you noticed that your child has recently experienced: [ ] Trouble getting to sleep [ ] Frequent waking
[ ] Early rising [ ] None of these problems

Have you noticed that your child's sleeping habits have changed in the last 6 months? [ ] Yes [ ] No

If so, how? ____

Have you noticed that your child has been: [ ] Under eating [ ] Starving self [ ] Over eating [ ] Eating with no trouble

Does your child eat: [ ] A well balanced diet [ ] Junk food [ ] Fast foods [ ] Whatever is available

Have you noticed that your child's eating habits have changed in the last 6 months? [ ] Yes [ ] No

If so, how? ____

Developmental Issues:

Pregnancy was: [ ] Normal [ ] Problematic

Note any problems: ____

Delivery was: [ ] Normal [ ] Problematic [ ] Premature

Note any Problems: ____

Child walked at age: ____________ Note any problems: ____

Child began talking/using language: ____________ Note any problems: _______________________________

Child began school: ____________ Note any problems: ____

Child began drawing:____________ Note any problems:____

Child began writing: ____________ Note any problems: ____

Has your child been immunized?
Has your child had hearing/vision screening?

School performance: [ ] A-B Student [ ] B-C Student [ ] C-D Student [ ] Failing

School behavior:

____

Have you noticed any change in your child's behavior or performance in school during the last school year? [ ] Yes [ ] No

Has your child's grades recently dropped? [ ] Yes [ ] No

Has your child ever repeated a grade? [ ] Yes [ ] No

Has your child ever been enrolled in special education classes? [ ] Yes [ ] No

Has your child ever been suspended from school? [ ] Yes [ ] No

Has your child ever been expelled from school? [ ] Yes [ ] No

Do you feel that drugs or alcohol have interfered with your child's education? [ ] Yes [ ] No

Alcohol/Drug Use:

Does your child smoke cigarettes?

If so, are they permitted to do so in the house?

Do you have any reason to believe that your child has been using alcohol or other drugs that have not been prescribed for them? [ ] Yes [ ] No

If so, what concerns do you have about this? ____

What kinds of problems (if any) has alcohol or other drug use contributed to in your family to date? __________________

____

Additional Information: Do you have anything to add to this information: ______________________________________

____

____

____

____ _________________________________

(Signature of Person Providing Information) (Date)

____

(Relationship to Patient)

I have reviewed this questionnaire with the patient/client:

____ _________________________________

(Therapist Signature and Credentials) (Date)

Revision: 11/99 SLM