BRINDLEY GROUP, LLC
Initial Assessment Child/Adolescent Parent Questionnaire

Client Name: _____ Preferred name: _____ Date: _____

Date of Birth: __/__/___ Age of Client: ___ Preferred telephone # : _____ Email: _____

Name of person(s) completing form: _____ Relationship to Client: _____

Dear Parent/Guardian: The information that you provide is very helpful and critical in providing an accurate understanding of your concerns. Please write on the back of the page if there isn't enough space to share all the information.

1. Please describe, in detail, the present concern/problem (including when the problem started, how often it occurs, what stressors may contribute to the problem) and any other changes you have recently noticed in your child.
Also, include *any recent changes that have occurred within your family and/or in your child's environment.*

_____
_____
_____
_____
_____

2. Medical History:

Name of Pediatrician or Family Doctor: _____ Date last seen: _____

Please circle any of the following medical conditions for which your child has experienced:

Seizures	Asthma	Eating disorder	Stomach Problems	Sleep Problems
Anxiety	Chronic Headaches	Suicidal Thoughts	Head Injury	Appetite concerns
Depression	Heart Problems	Chronic Fatigue	Self-harm	Physical Aggression
Pain	ADHD	Dental Problems	Cancer	Urinating or bowel movements on self/underwear after potty trained

Surgeries: _____

Any other medical condition or concern:_____
_____

Please describe how your child and family are affected and cope with any of the above medical conditions:_____
_____
_____

Please list any medication(s) or treatment that was *previously* prescribed for these conditions:
_____

Current Medications and dosages (including prescription, over the counter, herbal, and other supplements)**:**
_____
_____

Date of your child's last hearing and eye checkup, as well as any history of problems with hearing or vision:
_____

Drug Allergies:
_____

Caffeine intake per day:
_____

Sugar intake/How healthy does your child eat?/ Picky?
_____

3. Past Psychiatric/Counseling History:

Has your child ever received psychiatric, psychological, or counseling services? Yes No
If yes, please explain and include reason, dates of service, location, physician, or counselor's name.

What was helpful and unhelpful about the services listed above?

Has your child ever had any psychological testing done, including IQ testing? Yes No
If yes, please describe the findings: _____

List any psychiatric medications that your child has been prescribed in the past:

List any current or past concerns about your child using alcohol or drugs (nicotine, prescription, or illegal substances):

Has your child ever attempted or had thoughts of suicide or homicide?

4. Developmental History:

Was your child planned? Yes No If not, please describe what this was like:

Describe stressful experiences during pregnancy (i.e., relationships, abuse, job stress, finances):

Were there any complications during pregnancy? Yes No If yes, explain:

Did either parent use drugs or excessive alcohol at the time of conception or during pregnancy? Yes No If yes, explain:

Were there any complications with the labor/delivery such as jaundice, infection, emergency C-section? Yes No If yes, explain:

Child's estimated weight at birth: __lbs. ____oz. Was this a full term birth? Yes No If no, explain:

Were there any problems after birth? Yes No If yes, explain:

Did the child's mother experience post-partum depression? Yes No If yes, explain:
_____

Was your child breastfed? Yes No If yes, how long? _____
What was your child's response to nursing and/or given a bottle? _____
What was your response and your child's response to weaning off nursing and/or bottle?_____
_____
Describe how your child fell asleep as an infant:_____
Describe current sleep challenges, if any:_____

Please circle the following items that describe your child's temperament as an infant/toddler.

Did not enjoy being held	Feeding/Eating problems	Sensitive to light/noise/texture
Excessive restlessness	Sleep problems	Fussy or unhappy
Colic	Head-banging	Difficulty bonding

Any behaviors or concerns you had about your child up until age 5:
_____
_____

Who was your child's primary caretaker during these times?
Birth to 6 weeks: _____
6 weeks to 2 years: _____
2–5 years of age: _____

Any significant family stressors/deaths/changes <u>with the primary caretakers</u> during your child's first five years? Yes No
Any concerns about any caretakers? Yes No
If yes to either, please explain:_____
_____
_____
_____

If you are fostering a child or have adopted your child, please describe in detail as much information as possible about how this has been for you, your child and family. Please use the back of page as needed. _____
_____
_____

Developmental Milestones: Please indicate the approximate age in months/years when your child achieved the following tasks:
Sitting alone _____ Walking _____ Put words together _____ Toilet trained _____

Circle or note any unusual behaviors/speech patterns:

Spinning	Putting things in the mouth	Repeating words or phrases inappropriately	Tantrums
Hand flapping	Sniffing excessively	Saying "I" for "You"	OTHER:

5. Preschool/Daycare/Education History:

Did your child attend daycare? Yes No If yes, at what ages? _____ Concerns? _____
On a scale of 1 (no nurturing) -10 (most nurturing) what do you believe your child's receives at daycare (past or present)_____/_____ and at school (past and present)_____/_____.
Name of current school and grade: _____
What is your impression of your child's relationship with his/her teachers?_____
_____
What is your impression of your child's relationship with his/her peers? _____
_____
What were your child's scores/grades, including conduct on their last report card? _____
_____
Please describe any academic or behavioral concerns or difficulties: _____
_____
_____
_____

Name of **Past Schools, if in a different district**:

_____ Grades Attended: _____
_____ Grades Attended: _____

Has your child ever been…and if so, please comment on specifics:

Evaluated for a learning disability? Yes No _____
Does your child have a current IEP (Individual Education Plan)? Yes No _____
Does your child have a current 504 plan? Yes No _____

6. Family Medical and Mental Health History:

Please list any significant family medical history (i.e., cancer, heart disease, seizures, diabetes):
_____
_____

Please note mental health issues with family members (i.e., depression, suicide, anxiety, eating disorders, abuse, OCD, personality disorders, Schizophrenia, head injury): _____
_____
_____

Please note any family alcohol and drug issues (prescription and illicit drug use): _____
_____
_____

Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child ever been arrested or had legal problems? Yes No If yes, please describe and use back for more space:
_____

Has there been any DHR involvement with any family member? Yes No If yes, please describe and use back for more space:
_____

7. Social / Family History:

Ethnic background/previous country/state/city where child has lived: _____
Religious affiliation and/or spiritual beliefs: _____

Involvement in client's childhood:

	Present entire childhood	Present part of childhood	Not present at all
name of parent_____	[ ]	[ ]	[ ]
parent_____	[ ]	[ ]	[ ]
stepparent	[ ]	[ ]	[ ]
stepparent	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

Parents' current marital status:
[ ] married to each other
[ ] living together/committed
[ ] separated for __ months/years
age of client at separation _____
[ ] divorced for __ months/years
age of client at divorce _____
[ ] mother remarried __ times
[ ] father remarried __ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for __ months/years
age of patient at mother's death __
[ ] father deceased for __ months/years
age of patient at father's death ____

Describe client's childhood family experience:
[ ] excellent home environment
[ ] normal home environment
[ ] chaotic home environment

Describe an overview of your child's childhood:_____
_____

On average how much time does your child spend on social media/electronics/TV per weekday :_____ per weekend:_____

How much time do you, parents, spend on social media/TV/phone when child present per weekday: _____per weekend:_____

On average how much time does your child spend outdoors, weather permitting, per weekday:_____ per weekend:_____

Describe client's parents:

Full name	_____	_____
Age	_____	_____
Occupation (i.e., homemaker, sales, nurse)	_____	_____
Highest level of education	_____	_____

List all persons (and pets) currently living in patient's primary household:

Name	Age	Sex	Describe type of relationship (Ex. Brother/distant/close)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List parent/siblings <u>not</u> living in same household:

Name	Age	Sex	Describe type of relationship (Ex. Step mom/like a friend)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<u>Place a STAR by the names of the people listed above who you believe your child has the closest connection/relationship with.</u>

How often does your child interact with those that do not live in his/her home?_____

Describe any past or current significant issues in <u>immediate family</u> relationships: _____

_____

_____

What type of discipline has been used both in the past and currently with your child? What has been ineffective and effective? Any concerns about discipline your child has received by any caretaker? Please include discipline utilized by all caretakers.

_____

_____

How does your family handle conflict?

_____

Has your child ever been a victim of child physical, verbal, emotional, or sexual abuse by any individual? Yes No
If you answered yes to any of these questions, please explain:

_____

_____

_____

Has your child shown physical, verbal, or sexual abuse toward others? Yes No If yes, explain:

_____

_____

Has your child *witnessed* physical, verbal, or sexual abuse toward others? Yes No If yes, explain:

_____

_____

What would you like to improve for your child/adolescent?

_____

_____

What would you like to improve for your family?

_____

_____

Any further information we did not ask that would be helpful for us to know in order to help your child (use back as needed):

_____

Thank you for this information and for the opportunity to serve your child.