NEW ENGLAND CENTER
FOR MENTAL HEALTH

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Parent Questionnaire

Name of person completing form _____ Relationship _____
Please list the reason for your visit today: _____
_____
_____
What are your child's strengths? _____
_____
_____

Current Medications

Psychiatric medications:

Name	*Dose*	*Frequency*	*When Started*	*Prescribed by*

Non-psychiatric medications (prescription):

Name	*Dose*	*Frequency*	*When Started*	*Prescribed by*

Over-the-counter medications:

Name	*Dose*	*Frequency*	*When Started*	*Prescribed by*

Drug Allergies: _____
_____
_____

Has your child received Mental Health services before? _____

Hospitalizations: ☐ yes ☐ no Total # of hospitalizations: _____
Age of first hospitalization: _____

Please list the 3 most current hospitalizations beginning with the most recent:

Dates (from-to) *Facility* *Reason*

_____
_____
_____

Has your child received **counseling** before?

Name *Address* *Phone Number* *Dates of Treatment* *Results*

_____
_____
_____

Has your child received **medication evaluations** before?

Name *Address* *Phone Number* *Dates of Treatment* *Results*

_____
_____
_____

Previous Medications

Name *Dose* *Frequency* *Started and Stopped* *Reason for Removal*

_____
_____
_____

Has your child had any frightening or traumatic experiences? If yes, please describe.

Accident
- ☐ Yes _____
- ☐ No

Medical trauma
- ☐ Yes _____
- ☐ No

Other
- ☐ Yes _____
- ☐ No

Has your child ever experienced sexual or physical abuse? If yes, please describe.

Physical abuse
- ☐ Yes _____
- ☐ No

Sexual abuse

- ☐ Yes _____
- ☐ No

Sexual assault

- ☐ Yes _____
- ☐ No

Neglect by parent(s)

- ☐ Yes _____
- ☐ No

Neglect by relative(s)

- ☐ Yes _____
- ☐ No

Has your child ever been a witness to violence? If yes, please describe.

Witness to domestic violence

- ☐ Yes _____
- ☐ No

Witness to other violence

- ☐ Yes _____
- ☐ No

Do you suspect or know that your child/teen has been using/abusing any of the following?

Substance	Date of last use	Age of first use	Method of use	Amount/Frequency of use	Type
Alcohol					
Marijuana					
Tobacco					
Cocaine					
PCP					
Heroin					
Sedatives					
Amphetamines					
Prescription Drugs					
Internet					
Video Games					
Other					

Has your child/teen ever been to a detox program or drug rehab program? ☐ yes ☐ no

If yes, when? _____ where? _____

Medical History

Has your child ever had any of the following health problems?	Yes	No	When
1. Loss of consciousness or head injury	☐	☐	
2. Seizures or convulsions	☐	☐	
3. Rashes or skin problems	☐	☐	
4. Meningitis	☐	☐	
5. Asthma	☐	☐	
6. Food allergies	☐	☐	
7. Drug or medication allergies	☐	☐	
8. Pneumonia	☐	☐	
9. Anemia or low blood count	☐	☐	
10. Heart Problems	☐	☐	
11. Kidney or urinary problems	☐	☐	
12. Bowel problems	☐	☐	
13. Trouble with vision	☐	☐	
14. Trouble with hearing	☐	☐	
15. Lack of weight gain	☐	☐	
16. Poisoning or medication overdose	☐	☐	
17. Serious injury	☐	☐	
18. Hospitalization	☐	☐	
19. Surgery	☐	☐	
20. Diabetes	☐	☐	
21. Sexually active	☐	☐	
22. Last menstrual period			

Child's Development

Pregnancy

Age of mother at time of delivery: _____

Birth order: _____

Parental Relationship at the time of the pregnancy: _____

Relationship to pregnancy:

- ☐ Planned
- ☐ Unplanned
- ☐ Wanted child
- ☐ Did not want child

Complications: _____

Months gestation: _____

Substance use: ☐ yes ☐ no

Substance:
- ☐ cigarette frequency: _____
- ☐ cocaine frequency: _____
- ☐ marijuana frequency: _____
- ☐ alcohol frequency: _____
- ☐ other illegal drugs frequency: _____

Prenatal care: ☐ yes ☐ no Started when: _____

Postnatal

Medical Complications:

- ☐ Jaundice
- ☐ Infections
- ☐ Respiratory problems
- ☐ Heart problems
- ☐ Need for incubation
- ☐ Other _____

Postpartum depression for mother:

- ☐ Yes
- ☐ No

Feeding:

- ☐ Breast fed
- ☐ Bottle fed
- ☐ Vomiting
- ☐ Colic
- ☐ Diarrhea
- ☐ Food allergies
- ☐ "picky" eater

Slept through the night at age: _____

Birth

Labor difficulties:

- ☐ C-section
- ☐ Prolonged labor
- ☐ Breach birth
- ☐ Loss of oxygen
- ☐ Other _____

- ☐ twin
- ☐ triplet
- ☐ other multiple birth

Weight: _____lbs _____oz Length: _____in

Location: _____

Comments: _____

_____

When did your child do the following?

Sat unsupported at: _____ months

Crawled at: _____ months

Walked at : _____ months

Talked – first word at: _____ months

Two word phrases: _____ months

Toilet Training

Fully toilet trained at: _____ months

Continue to have difficulty?

- ☐ Yes
- ☐ No

Wetting:

- ☐ Day
- ☐ Night

Soiling:

- ☐ Day
- ☐ Night

Frequency: _____ Incidents in the past: _____

Early Development

To whom is the child primarily attached?

- ☐ Mother
- ☐ Father
- ☐ Other _____

Who else is the child strongly attached to? _____

_____

_____

Did the child experience a change in caretakers before the age of 3?

- ☐ Yes
- ☐ No

Please describe: _____

Please answer the following questions about your child for the first three years of his/her life:

Question	Frequently	Sometimes	Never
1. Enjoyed being held			
2. Was alert to surrounding environment			
3. Explored the surrounding environment			
4. Was active			
5. Interacted with adults			
6. Interacted with other children			
7. Was predictable in terms of sleeping-waking patterns.			
8. Slept soundly (no rocking or unusual movement)			
9. Was predictable in terms of bowel and bladder patterns.			
10. Was predictable in terms of hunger patterns.			

How old was the child when they entered daycare/preschool/early intervention or other program? ____

List specific programs and approximate dates (including full or half-day babysitting):

Name of program	*Date*	*Beneficial / Helpful*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any changes in daycare and/or preschool arrangements. Please describe why these occurred:

_____

_____

_____

Separation

Have their been separations of your child from either parent?

	Dates:	Please describe and child's reaction:
Father:		
☐ Yes	_____	_____
☐ No		_____
		_____
Mother:		
☐ Yes	_____	_____
☐ No		_____
		_____

Was either parent unable or unwilling care for the child at any time?

- ☐ Yes
- ☐ No

If yes, please describe reason and child's reaction: _____

_____

_____

Family Illnesses

Illness	**Biological Mother**	**Biological Mother's Family**	**Biological Father**	**Biological Father's Family**	**Siblings**	**Others**
Allergies						
Asthma or Emphysema						
Diabetes						
Heart Trouble						
Mental Retardation						
Seizure Disorder						
Depression						
Anxiety						
OCD						
Bipolar Disorder						
ADHD						
Schizophrenia						
Other Psychiatric Disorder						
Learning Difficulties						
Behavioral Problems						
Alcohol Dependency						
Drug Dependency						

Education/School Adjustment

Current School: _____
Current Grade: _____
Repeated Grade: ☐ yes ☐ no

Grade Repeated: _____

IEP:
- ☐ None
- ☐ Learning
- ☐ Behavior
- ☐ Learning and behavior

Suspensions / Expulsions: ☐ yes ☐ no
Describe: _____
_____
_____

Transfers: ☐ yes ☐ no
Describe: _____
_____
_____

Patient's understanding of special educational services: _____
_____
_____
_____

Language / Cultural Issues: ☐yes ☐ no
Describe: _____
_____
_____

Relationships with teachers: _____
Relationships with peers: _____
Strongest subjects: _____
Average grades: _____
Parents' relationship with school: _____

Work History

☐ No employment history

Place of Employment: _____
Length of Employment: _____
Number of Hours: _____

Occupation: _____
Employment History: _____
_____

Legal Problems

- ☐ None
- ☐ Arrests
- ☐ CHINS
- ☐ Probation
- ☐ DYS
- ☐ Victim / Witness
- ☐ Restraining order

Marital History

Would you describe your marital relationship as having:

- ☐ No Difficulties
- ☐ Occasional Difficulties
- ☐ Frequent Difficulties
- ☐ Not Currently Married

If married, what are the strengths of the marital relationship?_____

_____

_____

Describe significant marital problems and how they are viewed by both spouses:

Father:_____

Mother:_____

Have you received counseling for marital problems? Yes ☐ No ☐

If yes, please describe, state who provided services, when seen, and outcome of treatment:

_____

_____

Parent History

Biological Father

Date of Birth_____Birthplace_____Religion_____

Ethnic Origin_____Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Please describe any problems while you were growing up, particularly in reference to any personal and/or family problems:_____

_____

_____

Biological Mother
Date of Birth_____ Birthplace_____ Religion_____

Ethnic Origin_____ Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Please describe any problems while you were growing up, particularly in reference to any personal and/or family problems:_____

_____

Other Adult Care Takers (adoptive parents, step-parents, foster parents, other guardians)

Adoptive Step, Foster Father, or Male Guardian
Date of Birth_____ Birthplace_____ Religion_____

Ethnic Origin_____ Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Please describe any problems while you were growing up, particularly in reference to any personal and/or family problems:_____

_____

Adoptive, Step, Foster Mother or Female Guardian

Date of Birth_____ Birthplace_____ Religion_____

Ethnic Origin_____ Occupation_____

Place of Employment_____

Date of Marriage_____

If separated, divorced, widowed, or previously married, please specify and give dates:_____

_____

_____

Highest Educational Level Achieved:_____

Please list strengths:_____

_____

Please describe any problems while you were growing up, particularly in reference to any personal and/or family problems:_____

_____