BALANCED LIFE COUNSELING LLC

MINOR CHILD QUESTIONNAIRE

Minor's Name: ______________________________ Date: ______________

Mother: ____________ Father: ____________ Other: ______________

Phone #: ____________ Work Phone: ____________ Alt Phone: ______________

Are both parents together? [ ]Yes [ ]No

If no, who has legal custody? [ ]Mother (Name): ______________________

[ ]Father (Name): ______________________

[ ]Other (Name): ______________________

NOTE: Written consent must be given authorizing release of information if other than legal custodial parent or guardian.

Does child have other siblings? [ ]Yes [ ]No If yes, please give names and ages of each sibling:

____

____

Please tell us about your child's important developmental milestones. AGE WHEN. . . .

words were first spoken: ____________ child began using sentences: ____________

child started walking: ____________ first potty trained: ____________

Grade child is in: __________ Name of school: ______________________

Name of teacher(s): ______________________

____

Is your child experiencing academic difficulties? [ ]Yes [ ]No If yes, please explain: __________

____

____

If your child having behavioral issues at school or home? [ ]Yes [ ]No If yes, please explain:

____

____

Does your child have a learning disability? [ ]Yes [ ]No

Is child having difficulty with math, writing or language? [ ]Yes [No] If yes, please describe:

____

____

Does child exhibit any impaired socialization, such as: no eye-to-eye contact [ ] Yes [ ] No

No facial expressions: [ ]Yes [ ]No Poor body posture: [ ] Yes [ ] No

Any revenge seeking behavior: [ ]Yes [ ]No

Any issues in relationships with others? [ ]Yes [ ]No If yes, please explain: __________

____

____

Does your child point to things or people instead of using verbal language? [ ]Yes [ ]No If yes, explain:

____

Does the child try to involve others in what he/she is doing? [ ]Yes [ ]No If yes, explain: _____

____

Does child repeat any sound or words? [ ]Yes [ ]No If yes, what are they? ____________

____

Any motor mannerisms? (CIRCLE) Such as, flicking of hands, twisting of hair, pulling out hair, tapping on things, preoccupation with parts of objects, a tic? Any others? ______________

____

Has child demonstrated any interruption of others, doesn't wait his/her turn? Please circle which ones.

Rate child's home life: [ ] Great [ ] Good [ ] Pretty good [ ] Not too bad [ ] Bad Explain:

____

Any recent deaths/losses [ ]Yes [ ]No If yes, how long ago and who? ______________

____

What was child's relationship with this person: ____________________

____

Does your child have trouble sleeping? [ ]Yes [ ]No Does child have trouble getting to sleep, waking up, waking up? Does he/she have bad dreams, or nightmares? If so, please explain:

____

____

How is child'sbehavior in school versus at home? ____________________

Has your child ever expressed a desire to hurt himself/herself or others? [ ]Yes [ ]No If yes, when was the first occurrence: ____________________

Has your child ever hurt animals? [ ]Yes [ ]No If yes, please explain: ______________

____

____

Do you know what might have precipitated this behavior: [ ]Yes [ ]No If yes, please clearly describe what your child does: ____________________

____

____

Are you currently involved with the legal system (pending case, probation, parole, Child Protective Services)? [ ]Yes [ ]No If yes, please explain: ______________

____

____

____

GENERAL INFORMATION

Name of child's primary physician: ____________________

BALANCED LIFE COUNSELING LLC

Do you want your child's primary physician notified that your child is in counseling? [ ]Yes [ ]No
Please list any and all current medical problems and medications your child is taking: ________

Please list any allergies your child has to medication or food(s): ________

Who recommended Balanced Life Counseling to you?

What is the main reason for your child needing therapy: ________

Has your child previously received any mental health counseling? [ ]Yes [ ]No If yes, please state when, with whom and how it helped child: ________

Has child ever been hospitalized for mental health issues? [ ]Yes [ ]No If yes, please tell us when child was hospitalized and where: ________

Has child ever received treatment for substance abuse [ ]Yes [ ]No If yes, please explain what substance was used, duration and when: ________

Headaches	none	slight	serious	severe	overwhelming
Upset stomach	none	slight	serious	severe	overwhelming
Diarrhea	none	slight	serious	severe	overwhelming
Constipation	none	slight	serious	severe	overwhelming
Physical pain	none	slight	serious	severe	overwhelming
Problems with breathing	none	slight	serious	severe	overwhelming
Hot or cold spells	none	slight	serious	severe	Overwhelming
Sadness/depression	none	slight	serious	severe	Overwhelming
Thoughts of dying	none	slight	serious	severe	Overwhelming
No emotions	none	slight	serious	severe	Overwhelming
Quick change of moods	none	slight	serious	severe	overwhelming
Drawing away from people	none	slight	serious	severe	overwhelming

Tired a lot	none	slight	serious	severe	overwhelming
Loss of appetite	None	Slight	Serious	Severe	Overwhelming
Loss of weight without dieting # of lb.	None	Slight	Serious	Severe	overwhelming
Gaining weight without trying to # of lb.	None	Slight	Serious	Severe	Overwhelming
Wants to eat all the time	None	Slight	Serious	Severe	overwhelming
Racing thoughts	none	slight	serious	severe	overwhelming
Confusion	none	slight	serious	severe	overwhelming
Preoccupied	None	Slight	Serious	Severe	overwhelming
No interest in things of Life	none	slight	serious	severe	overwhelming
Difficulty concentrating	none	slight	serious	severe	overwhelming
Difficulties controlling my thoughts	none	slight	serious	severe	overwhelming
Difficulty keeping on task	None	Slight	Serious	Severe	overwhelming
Forgetful	none	slight	serious	severe	overwhelming
Forget in the middle of a thought	none	slight	serious	severe	overwhelming
Dwelling on problems	none	slight	serious	severe	overwhelming
See/hear strange things	none	slight	serious	severe	overwhelming
Difficulty communicating	none	slight	serious	severe	overwhelming
Overly talkative	None	Slight	Serious	Severe	overwhelming
Hyperactivity	None	Slight	Serious	Severe	overwhelming
Restless/can't sit still	none	slight	serious	severe	overwhelming
Nervous/tense	none	slight	serious	severe	overwhelming
Panicky	none	slight	serious	severe	overwhelming
Shaky/trembling	none	slight	serious	severe	overwhelming
Irritability	none	slight	serious	severe	overwhelming
Worries about a lot of things	None	Slight	Serious	Severe	overwhelming
Anger	None	Slight	Serious	Severe	overwhelming
Feeling helpless	none	slight	serious	severe	overwhelming
Feeling Hopeless	None	Slight	Severe	serious	overwhelming
Feeling worthless	none	slight	serious	severe	overwhelming

Feels ignored/abandoned/rejected	None	Slight	Serious	Severe	overwhelming
Feeling lonely	None	Slight	Serious	Severe	overwhelming
Feeling used by others	None	Slight	Serious	Severe	overwhelming
Hard to trust anyone	none	slight	serious	severe	overwhelming
Feels fearful	None	Slight	Serious	Severe	overwhelming
Feels like he/she is being watched	None	Slight	Serious	Severe	Overwhelming
Feels like someone/something controls him or her	None	Slight	Serious	Severe	overwhelming
Feels like others are out to get him or her	None	Slight	Serious	Severe	overwhelming
Low self esteem	None	Slight	serious	severe	overwhelming
Feeling negative about the future	None	Slight	Serious	Severe	overwhelming
Rebellious	None	Slight	Serious	Severe	overwhelming
Into drugs	none	slight	serious	severe	overwhelming
Into alcohol	none	slight	serious	severe	overwhelming
Into other drugs	none	Slight	Serious	Severe	overwhelming
Boyfriend/girlfriend problems	None	Slight	Serious	Severe	overwhelming
Sexual pproblems	None	Slight	Serious	Severe	overwhelming
Parents/step-parents Problems	none	slight	serious	severe	overwhelming
Problems with Friends	none	slight	serious	severe	overwhelming
Problems with Friends	none	slight	serious	severe	overwhelming
Problems at Work/school	none	slight	serious	severe	overwhelming
Health/medical problems	none	slight	serious	severe	overwhelming
Mental health	none	slight	serious	severe	overwhelming