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PARENT/GUARDIAN REPORT

DATE: ______________________

CHILD'S NAME: ____ **DATE OF BIRTH:** ______________________________

YOUR NAME: ____ **RELATIONSHIP:** ☐**PARENT** ☐**GUARDIAN**

YOUR PHONE # ________________________________ **CELL #** __________________________________

PEDIATRICIAN OR FAMILY PHYSICIAN: ____

Why are you seeking counseling or treatment services for your child at this time?

____

____

Please check any that apply: ☐ Vision Impairment ☐ Hearing Impairment ☐ SSI/Disabled ☐ Pregnant ☐ IV Drug User ☐ HIV+

Educational History:
☐Currently a student in grade ________ Name of school____

School Problems (check all that apply): ☐Attention Deficit/Hyperactivity Disorder ☐ Attention Deficit Disorder ☐Learning Disability ☐Behavioral Disability ☐ Reading Problems ☐Conduct Problems ☐ Suspensions ☐Expelled

☐ Failed grades # _________________ ☐Attendance Problems: Number of days absent from school in past month ________

Explain: ____

____

Age school problems began: _____ What has worked to help with these problems? ____

____

Does your child have an IEP (Individual Education Plan) or SST (Student Support Team)? ☐Yes ☐No

Has child experienced a traumatic event in past? Please check all that apply:

☐Domestic Violence ☐Abuse ☐Serious Accident ☐Other, please explain ____

Please indicate any past hospitalizations in a mental health facility, if any.

Facility Name	Date(s)	Reason
______________________________	____________________	____
______________________________	____________________	____

 Please continue on page 2.

Parent/Guardian Report

______________________________ ____________________ ____

Has your child taken any Psychiatric Medications in the past? Please check one: ☐Yes ☐No

If yes, please describe ____

Were they helpful? Please check one: ☐Somewhat ☐Yes ☐No

Is your child currently taking any Psychiatric Medications? Please check one: ☐Yes ☐No

If yes, please list current Psychiatric Medications:

1. ____________________________________ 2. ____________________________________

3. ____________________________________ 4. ____________________________________

Are they helpful? Please check one: ☐Somewhat ☐Yes ☐No

Does your child have a chronic physical health condition or serious illness? ☐Yes ☐No

If yes, please describe: ____

Is your child taking any medications for this physical health condition or illness? ☐Yes ☐No

If yes, please list/explain: ____

Does your child have any allergies or drug sensitivities? ☐Yes ☐No

If yes, which ones? ____

Are your child's immunizations up-to-date? ☐ Yes ☐ No

Please list the problems/events/significant losses and/or changes that are creating the most stress for your child at present time.

1. ____

2. ____

3. ____

4. ____

5. ____

What do you hope your child and your family will gain from our services?_______________________________________

____

____

Pediatric Symptoms Checklist (Questions 1-35)

Copyright 1988, M. S. Jellnick and J. M. Murphy, Massachusetts General Hospital.

Please select the response that best describes your child.

1. Complains of aches/pains ☐ 0-Never ☐ 1-Sometimes ☐ 2-Often
2. Spends more time alone ☐ 0-Never ☐ 1-Sometimes ☐ 2-Often
3. Tires easily, has little energy ☐ 0-Never ☐ 1-Sometimes ☐ 2-Often
4. Fidgety, unable to sit still ☐ 0-Never ☐ 1-Sometimes ☐ 2-Often

Item			
5. Has trouble with a teacher	□ 0-Never	□ 1-Sometimes	□ 2-Often
6. Less interested in school	□ 0-Never	□ 1-Sometimes	□ 2-Often
7. Acts as if driven by a motor	□ 0-Never	□ 1-Sometimes	□ 2-Often
8. Daydreams too much	□ 0-Never	□ 1-Sometimes	□ 2-Often
9. Distracted easily	□ 0-Never	□ 1-Sometimes	□ 2-Often
10. Is afraid of new situations	□ 0-Never	□ 1-Sometimes	□ 2-Often
11. Feels sad, unhappy	□ 0-Never	□ 1-Sometimes	□ 2-Often
12. Is irritable, angry	□ 0-Never	□ 1-Sometimes	□ 2-Often
13. Feels hopeless	□ 0-Never	□ 1-Sometimes	□ 2-Often
14. Has trouble concentrating	□ 0-Never	□ 1-Sometimes	□ 2-Often
15. Less interest in friends	□ 0-Never	□ 1-Sometimes	□ 2-Often
16. Fights with others	□ 0-Never	□ 1-Sometimes	□ 2-Often
17. Absent from school	□ 0-Never	□ 1-Sometimes	□ 2-Often
18. School grades dropping	□ 0-Never	□ 1-Sometimes	□ 2-Often
19. Is down on him or herself	□ 0-Never	□ 1-Sometimes	□ 2-Often
20. Visits doctor/doctor finds nothing wrong	□ 0-Never	□ 1-Sometimes	□ 2-Often
21. Has trouble sleeping	□ 0-Never	□ 1-Sometimes	□ 2-Often
22. Worries a lot	□ 0-Never	□ 1-Sometimes	□ 2-Often
23. Wants to be with you more than before	□ 0-Never	□ 1-Sometimes	□ 2-Often
24. Feels he or she is bad	□ 0-Never	□ 1-Sometimes	□ 2-Often
25. Takes unnecessary risks	□ 0-Never	□ 1-Sometimes	□ 2-Often
26. Gets hurt frequently	□ 0-Never	□ 1-Sometimes	□ 2-Often
27. Seems to be having less fun	□ 0-Never	□ 1-Sometimes	□ 2-Often
28. Acts younger than children his or her age	□ 0-Never	□ 1-Sometimes	□ 2-Often
29. Does not listen to rules	□ 0-Never	□ 1-Sometimes	□ 2-Often
30. Does not show feelings	□ 0-Never	□ 1-Sometimes	□ 2-Often
31. Does not understand other people's feelings	□ 0-Never	□ 1-Sometimes	□ 2-Often
32. Teases others	□ 0-Never	□ 1-Sometimes	□ 2-Often
33. Blames others for his or her troubles	□ 0-Never	□ 1-Sometimes	□ 2-Often
34. Takes things that do not belong to him or her	□ 0-Never	□ 1-Sometimes	□ 2-Often
35. Refuses to share	□ 0-Never	□ 1-Sometimes	□ 2-Often

Supplemental Questions (Questions 36-41)

Item			
36. Threatens to harm self or attempts to kill self	□ 0-Never	□ 1-Sometimes	□ 2-Often
37. Threatens or attempts to hurt others	□ 0-Never	□ 1-Sometimes	□ 2-Often
38. Has displayed inappropriate sexual behavior	□ 0-Never	□ 1-Sometimes	□ 2-Often
39. Has reported seeing/hearing things others do not see/hear	□ 0-Never	□ 1-Sometimes	□ 2-Often
40. Seems out of touch with reality/lives in a fantasy world	□ 0-Never	□ 1-Sometimes	□ 2-Often
41. Thinks/reports others are out to get him or her	□ 0-Never	□ 1-Sometimes	□ 2-Often

Does your child have any emotional or behavioral problems for which he or she needs help? : ☐Yes ☐No

Describe any yes answers above: ______________________________

____

Are there any services that you would like your child to receive for these problems? ☐Yes ☐No

Describe any yes answers above: ______________________________

____

Comments/Additional Information:

Thank you for providing this information.