Central College Christian Counseling

Parent Interview Form

GENERAL INFORMATION

Name of child (identified patient) ___________________________________
Age of child: _____ Birth date of child: ___________
Parent completing form: ____________________________ Today's date: ____________

Give a brief summary of your main concern/presenting reason for bringing child to counseling:

____
____
____
____
____
____
____
____

When did the problems begin? ____
____
____
____
____
____

Describe any stress your family is currently experiencing: __________________________________
____
____
____
____
____

Has your child ever been in counseling? ______ If so, when? __________ For how long? ____________

Reason for past counseling: ____
____
____
____
____

Please answer all questions. Beside each item, indicate the degree & frequency of the problem using the following key:

N = never exhibited by the child; **P** = exhibited by child in the past;
C = exhibited by the child currently; **A** = exhibited by child throughout lifespan.

Item	Not at all	Occasionally	Frequently	Always
1. Picks at things (nails, fingers, hair, clothing).				
2. Sassy to grown-ups.				
3. Problems with making or keeping friends.				
4. Excitable, impulsive.				
5. Wants to run things.				
6. Sucks or chews (thumb, clothing, blankets).				
7. Cries easily or often.				
8. Carries a chip on his/her shoulder.				
9. Daydreams.				
10. Difficulty in learning.				
11. Restless in the “squirmy” sense.				
12. Fearful of new situations: new people or places; going to school.				
13. Restless, always up and on the go.				
14. Destructive.				
15. Tells lies or stories that aren’t true.				
16. Shy.				
17. Gets into more trouble than others same age.				
18. Speaks differently from others same age (baby talk, stuttering, hard to understand)				
19. Denies mistakes or blames others.				
20. Quarrelsome.				
21. Pouts and sulks				
22. Steals.				
23. Disobedient or obeys but resentfully.				
24. Worries more than others (about being alone; illness or death).				
25. Fails to finish things.				
26. Feelings easily hurt.				
27. Bullies others.				
28. Unable to stop a repetitive activity.				
29. Cruel.				
30. Childish or immature (wants help he shouldn’t need; clingy).				
31. Distractibility or attention span a problem.				
32. Headaches.				
33. Mood changes quickly and drastically.				
34. Doesn’t like or doesn’t follow rules or restrictions.				
35. Fights constantly.				
36. Doesn’t get along well with brothers and sisters.				
37. Easily frustrated in efforts.				
38. Disturbs other children.				
39. Basically an unhappy child.				
40. Problems with eating (poor appetite; up between bites)				
41. Stomach aches.				
42. Problems with sleep (can’t fall asleep; up too early; up in the night).				
43. Other aches and pains.				
44. Vomiting or nausea.				
45. Feels cheated in family circle.				
46. Boasts and brags.				
47. Lets self be pushed around.				
48. Bowel problems (frequently loose; irregular habits, constipation).				

MEDICAL INFORMATION

Name of Child's Physician:____ Date of Last Physical Exam:_______________

May we contact that physician if we deem necessary: ___Yes ___ No

Please describe the child's general health status: ____

1. To your knowledge does the child have any allergies? Yes No (If yes, specify): _______________________________
____

2. If the child has had any of the following medical conditions, please indicate by checking the box:

Chronic Ear Infections	Anemia	Asthma
Seizures	Measles (rubeola)	Rubella
Mumps	Chicken Pox	Scarlet Fever
Diphtheria	Rheumatic Fever	Heart Problems
Swollen Glands	Frequent Colds	Tonsillitis
Frequent Respiratory Infections	Convulsions	Head Injuries

Others (specify):____

3. Was there any observable changes in the child's behavior after or other unusual behavior following any of the illness marked in question #2? Yes No (If yes, specify):____

4. Are there any medical issues about the child you believe are important? Yes No (If yes, explain):___________________
____

5. Is the child currently on any medications? Yes No (If yes, list name and dosage):_________________________________
____

6. Does the child have any visual problems? Yes No (If yes, describe):____
____

7. Does the child have any speech problems? Yes No (If yes, describe): ____
____

HOME BEHAVIOR

All children exhibit to some degree the kinds of behavior listed below. Check those you believe your child exhibits to an excessive degree when compared to other children his or her age.

Hyperactivity (high activity level)	Poor attention span
Impulsivity (poor self control)	Low frustration threshold
Temper outbursts	Sloppy table manners
Interrupts frequently	Doesn't listen when spoken to
Sudden outbursts of physical abuse to other children	Acts as if he or she is driven by a motor
Wears out shoes more frequently than siblings	Doesn't seem to learn from experience
Excessive number of accidents	Heedless to danger
Poor memory	More active than siblings

DISCIPLINARY CONCERNS

Please check the box next to the disciplinary techniques you CURRENTLY use when your child behaves inappropriately. There also is space for writing in any other disciplinary techniques that you use.

Ignore problem behavior	Tell child to sit on chair
Scold child	Send child to his or her room
Spank child	Take away some activity or food
Threaten child	Don't use any technique
Reason with child	Other technique (describe):___________________
Redirect child's interest	____

1. What disciplinary techniques are usually effective?____
2. With what type of problem(s)? ____
3. What disciplinary techniques are usually ineffective?____
4. With what type of problem(s)? ____
5. What have you found to be the most satisfactory ways of helping your child? ________________________________

PSYCHOLOGICAL SOCIAL HISTORY

1. Has the child had previous testing or psychological examinations? Yes No
   If yes, may we contact the agency to receive a copy of the test results? Yes No
   If yes, please complete the Release of Information Form provided by Central College Christian Counseling.
2. Please describe the kinds of activities in which the child engages in the neighborhood and in the home. ______________________
3. Have there been any unusual changes or events recently in the home? Yes No (If yes, explain): ____________________
   Is there any evidence of emotional tension, fear, irritation or lack of confidence in the child? Yes No (If yes, please describe:____

PEER RELATIONSHIPS

Does your child seek friendships with peers? ________ Is your child sought by peers? ________

Does your child play primarily with children his/her own age? ________ Younger ________ Older ________

Briefly describe any problems your child may have with peers: ____

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SIBLINGS:

Give the following information on your child's siblings.

Name	Grade or Occupation	Sex	Age	Full	Half	Step	Adopted	Living at Home

Describe any medical, social, or academic problems of any sibling:

Name ______________________ Problem ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

LIVING ARRANGEMENTS

What types of moves have occurred during the child's lifetime?

1. Live in same place. ______________________
2. Moved between states. ______________________ Number of times ______________
3. Moved between cities. ______________________ Number of times ______________
4. Moved within the same city. ______________ Number of times ______________

FAMILY HISTORY – MOTHER

Present age ________ Age at time of patient's birth ________

School: Highest grade completed ________ Grade(s) repeated ______________________

Learning problems ______________________ Behavior problems ______________________

Medical problems (specify) ____

Have any of the maternal blood relatives ever had problems similar to those of the child? ________ If so, please note who and describe: ____

____

Has any family members on the mother's side had problems with:

Alcoholism	Mental Illness	Drug Abuse	Depression
Short attention span	Hyperactivity	Impulsive Behavior	

FAMILY HISTORY – FATHER

Present age ________ Age at time of patient's birth ________

School: Highest grade completed ________ Grade(s) repeated ________________________________

Learning problems ______________________________ Behavior problems ________________________________

Medical problems (specify) ____

Have any of the maternal blood relatives ever had problems similar to those of the child? ________ If so, please note who and describe: ____

____

Has any family members on the father's side had problems with:

Alcoholism Mental Illness Drug Abuse Depression
Short attention span Hyperactivity Impulsive Behavior

PREGNANCY

Complications: Please check any which occurred.

Fertility problems (specify) ____

Excessive vomiting ________ Spotting or blood loss? ___________ Hospitalization required? ________

Threatened miscarriage ________

Infection ________ Please Specify ____

Surgery ________ Please Specify ____

Toxemia ________ Other illness ________ Please Specify ______________________________________

Smoking during pregnancy ________ Average number of cigarettes per day ______________________

Alcohol consumption during pregnancy ________ Please describe amount ____________________________

List any medications taken during pregnancy ____

____

X-ray studies done during pregnancy ____

Duration of pregnancy ________________ Medical care during pregnancy began in what month?__________________

DELIVERY

Type of labor: Spontaneous ________ Induced ________

Forceps: High ________ Mid ________ Low ________

Duration of Labor: ________ hours Birth weight: ________________________

Type of delivery: Vertex (normal) ________ Breech ________ Cesarean ________

Complications: Cord around neck ________ Cord presented first ________ Hemorrhage ________

Infant injured during delivery ________ Other complications, please specify ____________________________

____

POST-DELIVERY PERIOD (while in hospital)

Respiration: immediate ________ delayed, please specify how long ______________________________

Cry: immediate ________ delayed, please specify how long ______________________________

Mucus accumulation ________ Apgar score (if known) ________ Jaundice ________

Incubator care ________ Number of days ________ Suck: strong ________ weak ________

Infection, please specify ____

Vomiting ________ Diarrhea ________

Birth defects, please specify ____

Total number of days baby was in the hospital after the delivery ____________________________________

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INFANCY-TODDLER PERIOD

Were any of the following present to a significant degree during the first few years of life? If so, please describe:

Did not enjoy cuddling ______________________________

Was not calmed by being held and/or stroked ______________________________

Colic ______________________________

Excessive Restlessness ______________________________

Diminished sleep because of restlessness or easy arousal ______________________________

Frequent headbanging ______________________________

Excessive number of accidents compared to other children his/her age ______________________________

Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions ______________________________

____

Age at time of toilet training? ________ Any complications? ______________________________

EARLY SCHOOL YEARS

Consistent failure to speak in specific social situations ______________________________

Distress during times of separation from home or attachment figures ______________________________

EDUCATIONAL CONCERNS

Place a check next to any educational problem that your child currently exhibits:

Has difficulty with reading

Has difficulty with arithmetic

Has difficulty with spelling

Has difficulty with writing

Has difficulty with other subjects (describe):

____

____

____

OTHER INFORMATION

What are your child's favorite activities?

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
6.______________________________

What activities would your child like to engage in more often than he or she does at present?

1.______________________________
2.______________________________
3.______________________________
4.______________________________

What activities does your child like least?

1.______________________________
2.______________________________
3.______________________________
4.______________________________

Thank you for your time and honesty.