EAGLE CONSULTING
COUNSELING DIVISION
making a life difference

Questionnaire for Parents/Legal Guardian

Thank you for your time and effort in completing these forms. They provide very valuable information for therapy that helps provide excellence in the counseling process. Your information will be kept private and confidential. Thank you for choosing Eagle Consulting to assist you in this time of your life.

Person completing this form:			Date:
Relationship to child/adolescent:			
Child's Name:	☐ M ☐ F	Age:	DOB:
Please describe in detail, the concerns that prompted you to bring your child to therapy (including when the problem started and how often it occurs, and what stressors may contribute to the problem, etc.)			
Has your child received any previous psychiatric or counseling treatment? ☐ Yes ☐No If yes, please explain.			
Please include provider's name and dates of services:			
Please describe your goals or expectations for the counseling process:			

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Medical History

Name of Family Doctor:	Date last seen:
Name of Psychiatrist:	Date last seen:

Please check any of the following conditions for which your child was every evaluated or diagnosed:

☐Seizures	☐Heart Problems	☐Weight Problems	☐Head Injury
☐Asthmatic condition	☐Chronic Fatigue	☐Chronic Headaches	☐Depression
☐Hearing Loss	☐Stomach Problems	☐Allergies	☐Anxiety/Panic
☐ADHD	☐Learning Disability	☐Other (explain):	

Please explain any item that you checked:

Please list any **P**reviously or **C**urrent medication prescribed to child:

Name of Medication/Provider	Dosage	Side Effects:
☐P ☐C		
☐P ☐C		
☐P ☐C		
☐P ☐C		
☐P ☐ C		

Counselor Notes:

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Developmental History

Were there any complications with the labor and delivery? ☐No ☐Yes, please explain:

Were there any problems after birth? ☐No ☐Yes, please explain:

Pre-school/Toddler Temperament: Please check any of the following that apply:

☐Did not enjoy being held	☐Excessive relentlessness	☐Colic	☐Feeding problems
☐Sleep problems	☐Sensitive to light/noise/texture	☐Head-banging	☐Fussy or unhappy

Please describe any problems with developmental milestones:

Name of Current School:	Current Grade	Behavior Problems:	Learning Problems:
		☐Yes ☐No	☐Yes ☐No

Please explain any current problems:

Name of Past Schools:	Dates Attended	Behavior Problems:	Learning Problems:
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No

Please explain any past problems:

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Family History

Please indicate whether any blood relatives have had any of these concerns:

	Parents	Siblings	Grandparents	Aunts/Uncles
Depression	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Alcohol/Drug	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Suicide	☐	☐	☐	☐
Other:	☐	☐	☐	☐

Mother's Name:	Father's Name:
Step-mother's Name:	Step-father's Name
If divorced, who has custody of child:	Age of child when divorced:

***A custody order by the court must be provided for the file at initial appointment.**

If divorced/separated, please describe living arrangements, visitation schedule, and any conflict that may exist.

List all those living in the child's home:

Name	Relationship	Age/School/Occupation

List other person's closely involved with child but not living in the home:

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Symptom Checklist

Please check any stressors or problems you believe your child currently struggles with:

☐Peer relationships	☐Health problems	☐Legal problems	☐Drug/Alcohol	☐Tobacco
☐Family relationships	☐School problems	☐Anxious mood	☐Depressed mood	☐Anger
☐Employment problems	☐Low energy	☐Mood swings	☐Appetite	☐Worry
☐Academic problems	☐Concentration	☐Nightmares	☐Temper	☐Fears
☐Bingeing/Purging	☐Isolates	☐Immature	☐Argues	☐Lying
☐Bullying issues	☐Frequent moves	☐Obsessions	☐Compulsions	☐Authority
☐Suicidal ideations				
☐Other:				

Counselor Notes:

Thank you so much for completing these forms. We want your child's therapy process to be successful. Please feel free to ask your counselor any questions you may have at any time. Thank you for choosing and trusting Eagle Consulting/Counseling Division to make a difference in your life!

www.counselingtec.com