Date: _____

Client's Name: _____

Madraigos Midwest
Mozes & Helen Stern Counseling Center
Parent Assessment

Presenting Problem:

What is the primary reason you are requesting counseling services for your child? What are you most concerned about at the present time?

_____

_____

_____

_____

_____

_____

_____

When did this (problem) begin?

_____

Are there any other significant events that contribute to this or other issues your child is dealing with?

_____

_____

_____

_____

_____

Has anyone else expressed concern about your child? (Ie: Teachers, extended family, friends, etc.)

_____

_____

_____

_____

Family History

Parents married, divorced or separated?

_____

Mother's Name:

_____

Description of relationship with your child: (Good, Fair, Poor)

_____

_____

Father's Name:

_____

Description of relationship with your child: (Good, Fair, Poor)

_____

_____

*Step-parent's name:

_____

Description of relationship with your child: (Good, Fair, Poor)

_____

_____

Please list names of siblings, their ages, and quality of relationship (good, fair, poor):

Name	Age	Quality of Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Optional) Family's religious status:

Orthodox _____ Conservative _____ Reform _____

Non-Affiliated _____ Other Religion _____

What are some of your family stressors (marital, financial, medical, extended family, etc.)?

_____

_____

_____

Is there anyone in the home that you believe to be abusive (sexually, physically, verbally, financially and/or emotionally)?

_____

_____

_____

_____

Do you believe that your child has been or is being abused (sexually, physically, verbally, financially and/or emotionally)?

Is there anyone in the home whose addictive behaviors (ie: substance, alcohol, illegal presciption drugs, pornography, etc.) impact your child?

Are there any ongoing legal issues that are impacting your child?

Has there been DCFS involvement in your family at any point?

Child's Developmental History (ages 0-5):

Problems experienced during pregnancy and delivery?

Birth complications or problems?

Difficulty bonding?

_____

Early childhood medical/health problems?

_____

_____

Did your child receive any therapeutic services during preschool? (OT, PT, Speech, Social skill etc.)

_____

_____

_____

_____

Child's Current Health/Medical Information

Primary Care Physician:

_____

Conditions currently being treated:

_____

Circle all that apply to your child and provide basic details.

Allergy_____

Sleep concerns (ie: oversleeping or insomnia)

_____

Eating/weight concerns

_____

Tobacco use

_____

Substance use

_____

Other addictive behaviors

_____

Child's Mental Health:

Does your child typically express feelings of (*check all that apply*):

Sadness/Depression ____	Anger ____	Other (please list):
Anxiety ____	Hopelessness ____	_____
Fear ____	Guilt ____	_____
Stress/Overwhelm ____	Remorse ____	_____

How would you describe your child's personality (*check all that apply*)?

Intense ____	Agreeable ____	Friendly ____
Passive ____	Likeable ____	Withdrawn ____
Motivated ____	Self-Defeating ____	Reserved ____
Engaged ____	Argumentative ____	Indifferent ____
Cooperative ____	Confident ____	Helpful ____
Sensitive ____	Hopeful ____	Other: ____

In the past, has your child attended out-patient therapy? If yes, when and with whom?

_____

_____

_____

Currently, is your child in any form of psychotherapy? If yes, where?

_____

_____

_____

Has your child ever attended a daily partial hospitalization program (PHP)?

_____

_____

Has your child ever been hospitalized for psychiatric treatment?

_____

_____

Medications (*psychotropic*):

Past:

Dates	Type	Dosage	Prescribing Doctor

Present:

Dates	Type	Dosage	Prescribing Doctor

Please identify the treatment goals that you have for your child:

_____

_____

_____

_____

Educational History:

Highest grade level achieved: _____

Learning difficulty/disability?

_____

Does your child have any school related behavioral struggles? If yes, please explain.

_____

_____

_____

School History:

School	Grades	Years

Social-Emotional History

What are your child's strengths, positive traits, and talents?

How does your child spend their free time?

Describe strengths and gaps in your child's social skills and friendships?

Who are the other significant people in your child's life that are supportive of his or her growth?

Is there anything else your child's therapist should know that doesn't appear on this form?

_____

_____

_____

_____

_____

_____