DELAWARE COUNTY BEHAVIORAL HEALTH

MENTAL HEALTH SERVICES
FAMILY & CHILDREN SERVICES
ADDICTION SERVICES

243 DELAWARE STREET
WALTON, NY 13856

TELEPHONE (607) 832-5888
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CYNTHIA HEANEY, LCSW
DIRECTOR OF COMMUNITY SERVICES

PARENT/CHILD QUESTIONNAIRE

Child's Last Name: ______________________ First: ____________________ DOB: ____/_____/____

PRESENTING CONCERNS

Why did you contact the clinic now?____

____

____

____

HISTORY OF MENTAL HEALTH TREATMENT

Has the child ever seen a therapist or been psychiatrically hospitalized?_____If so, who was the provider and how long were they in treatment?____________________

____

____

____

What was helpful or not helpful while in treatment?___________________________

____

____

____

FAMILY COMPOSITION

Child's brothers and sisters: (please provide age and present whereabouts)

Name:____Age:______Town:___________

Name:____Age:______Town:___________

Name:____Age:______Town:___________

Name:____Age:______Town:___________

Name:____Age:______Town:___________

Does anyone else live with the family? (Please specify)________________________
____
____
____

FAMILY RELATIONSHIPS

Describe the parent and child relationship:____________________________________
____
____

What are positive activities you as a parent do with your child?_________________
____
____

As the parent(s), are you satisfied with the relationship you have with your child?__
____
____
____

Describe the relationship the child has with his/her siblings? ___________________
____
____
____

Describe the parent's/couple's relationship? _________________________________
____
____
____

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy: Any complications? ____
Did mother use drugs or alcohol when pregnant? ______________________________
____

Delivery: Any complications? If yes, please specify: __________________________
____

Breast Fed? ☐Yes ☐No How long?_____________
Describe any feeding problems?____
How would you describe this child as a baby?_________________________________
____

OTHER FAMILY INFORMATION

Mother's Occupation____

Father's Occupation____

Do Parents share custody?_____________________________________

If No, complete items below:

Parent/Guardian Name 1: _______________________________________

Type of custody? ☐Legal ☐Physical

Parent/Guardian Name 1: _______________________________________

Type of custody? ☐Legal ☐Physical

Is there any family history of drug or alcohol use?______ If yes, please specify?

____

____

Name of DSS Caseworker:_______________________________________

Was there a finding in Family Court or Criminal Court?_______If yes, what was the finding?____

____

Does anyone in the family have a criminal history?_____If yes, please describe___

____

____

TRAUMA HISTORY

Please check any of the following items which have happened to the child:

☐ Physical Abuse ☐ Community Violence ☐ Domestic Violence

☐ Witness to Violence ☐ Verbal/Emotional Abuse

☐ Sexual Abuse/Molestation ☐ Immigration Trauma

☐ Other ☐ None

For any trauma experience, please provide relevant details:____________________

____

____

PAST RISK AND CURRENT STRESSORS

School:____

Present Grade:_________Is this child classified by the Committee on Special Education?_______

If yes, how is he/she classified? _________________________________

Has this child ever failed a grade?_________If yes, please list__________________

____

Learning ability:____

Describe difficulties in school, with teachers, peers, subjects, etc.________________
____
Describe involvement in after-school activities (music lessons, church, sports, etc.)_
____
Describe child's attendance in school:____
____

TREATMENT GOALS

What are your goals in treatment?____
____
____
____
How will you know when you are better?_______________________________________
____
____
____

Name of person filling out this form:___________________________________

Relationship to Child:________________________________