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703C 60th Street Court East
Bradenton, FL 34208

INITIAL QUESTIONNAIRE FOR CHILD/FAMILY COUNSELING

What is the problem or concern that led you to seek therapy for your child? How long has this been a problem or concern?

Have you sought counseling in the past to address the concerns that brought you here? If so, who did you see and when? Was the counseling helpful or not and why?

Does the problem identified above cause difficulties with other family members? ☐ no ☐ yes If yes please explain.

Does the problem identified above cause difficulties with your child's peers and or friends? ☐ no ☐ yes If yes please explain

Does the problem identified above cause difficulties in your child's school or your job? ☐ no ☐ yes If yes please explain

Has your child experienced trauma? ☐ No ☐ Yes If yes please specify: ☐ Sexual Abuse ☐ Physical Abuse ☐ Auto Accident
☐ Domestic Violence (Witness or Participant) ☐ Fire (Witness or Involvement In) ☐ Gang Activities

CHECK ANY OF THE FOLLOWING FEELINGS AND BEHAVIORS THAT OFTEN APPLY TO YOUR CHILD

☐ Happy	☐ Hopeful	☐ Depressed	☐ Anxious	☐ Bored	☐ Helpless	☐ Fearful
☐ Anger	☐ Optimistic	☐ Annoyed	☐ Lonely	☐ Panic	☐ Conflicted	☐ Restless
☐ Tension	☐ Sad	☐ Energetic	☐ Shameful	☐ Relaxed	☐ Envious	☐ Jealous
☐ Unhappy	☐ Excited	☐ Content	☐ Excited	☐ Guilty	☐ Distracted	☐ Crying
☐ Difficulty Concentrating		☐ Loss of Control		☐ Procrastination		☐ Lazy

☐ Sleep Disturbances	☐ Odd Behavior	☐ Nervous Tics	☐ Racing Thoughts
☐ Temper Outbursts	☐ Impulsive Reactions	☐ Risky Behavior	☐ Eating Problem
☐ Smoke	☐ Excessive Worrying	☐ Use Drugs/Alcohol	☐ Problems in School
☐ Suicidal Thoughts	☐ Suicidal Attempts	☐ Withdrawal	☐ Trust Issues
☐ Bullying Behavior	☐ Physical Aggressiveness	☐ Verbally Aggressive	

CHECK ANY OF THE FOLLOWING MEDICAL ISSUES THAT APPLY TO YOUR CHILD

☐ Diabetes	☐ High Blood Pressure	☐ Seizures	☐ Heart Problems	☐ Asthma	☐ Skin Problems
☐ Kidneys	☐ Weight Management	☐ Arthritis	☐ Muscle/Joint Pain	☐ Headaches	☐ Stomach Problems
☐ Fatigue	☐ Urination/Bowels	☐ Tics	☐ Sexual Disturbances	☐ Nausea	☐ Menstrual Problems
☐ Numbness	☐ Immune System	☐ Tuberculosis	☐ Muscle Spasms	☐ Dizziness	☐ Ears/Nose/Throat

☐ Head Injury? If yes please indicate When _____ How _____
☐ Major Operations? If yes please explain _____

MEDICAL QUESTIONNAIRE

Who is your child's Primary Care Physician? _____ Okay to Contact? ☐ No ☐ Yes

Date of last physical Exam _____ Rate present physical health ☐ Good ☐ Fair ☐ Poor

Allergies? _____

Medication	Frequency	Prescribed by	Length of Use

I certify the information provided is true and up to date:

_____ _____
Client Signature Date

_____ _____
Client/Parent (Guardian) Signature Date

Client Name _____