

PARENTAL QUESTIONNAIRE - CHILD GUIDANCE SERVICE

PRIVACY ACT OF 1974

AUTHORITY: 5 U.S.C., Section 301; 10 U.S.C., Section 1071-1085; 50 U.S.C., Supplement IV, Appendix 454, as amended.
PRINCIPAL PURPOSE: Information will be used to assess an individual or family situation for proper treatment, staffing and assignment to a therapist within this department or to make an appropriate referral to another community source. Information will also be used to determine the type of assistance being requested, to evaluate other psychosocial background information, for proper identification for health record entries, for needs assessment, and for treatment and follow-up programs
ROUTINE USES: Information may be disclosed outside DOD agencies as outlined in DA Pam 25-51, paragraph 10-11f.
DISCLOSURE: Disclosure of information is voluntary; however, failure to provide requested information may slow the evaluation and treatment process.

PARENTS: So that we can decide how to offer the most useful kind of help, we will need more information about your child's problems and about your family. Therefore, we ask that both parents fill out this questionnaire as completely as possible and bring it with you to your first appointment. Use separate sheet(s) of paper if more space is required. This record will remain confidential and will not appear in your child's medical chart.

| | | | | | | | | | |
|------------------------------|------|--------------|-------------------|--------------|-------------|----------------|--|-----|--------------|
| CHILD'S NAME | | | CHILD'S BIRTHDATE | | CHILD'S AGE | | TODAY'S DATE | | |
| NAME AND ADDRESS OF SCHOOL | | | | | | TEACHER'S NAME | | | |
| | | | | | | GRADE | MAY WE CONTACT THE SCHOOL? | | |
| | | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | |
| SPONSOR'S NAME | | | SPONSOR'S SSN | | AGE | | MILITARY STATUS | | |
| BRANCH OF SERVICE | RANK | DUTY ADDRESS | | | | | DUTY PHONE | | |
| HOME ADDRESS | | | | | | HOME PHONE | | | |
| SPOUSE'S NAME | | | | | AGE | | OCCUPATION | | |
| WHO REFERRED YOU TO US | | | | | | | | | |
| OTHER CHILDREN IN THE FAMILY | | | | | | | | | |
| NAME | | SEX | AGE | SCHOOL GRADE | NAME | | SEX | AGE | SCHOOL GRADE |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

QUESTIONS TO BE ANSWERED BY THE PARENTS OF THE CHILD

As completely as possible, please describe the problem you feel your child has or the reason you brought your child to this clinic.

What do you think may have caused _____ problem(s)?

What do you want this clinic to do for you and your child?

Rate your child with regard to school experiences, learning, adjustment in school:

| | GOOD | AVERAGE | POOR |
|-------------------|--------------------------|--------------------------|--------------------------|
| a. Nursery school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Kindergarten | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Current grade | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Describe any school problems and/or any kind of special therapy or remedial work your child is currently receiving.

How does your child get along with other children?

How would you describe your child's personality?

At what age did your child do the following things?

| | | | | | |
|-------------------------|-------|------------------------------------|-------|------------------------------------|-------|
| Sit up | _____ | Speak in sentences | _____ | Start school | _____ |
| Stand alone | _____ | Count to ten | _____ | Read fairly well | _____ |
| Walk alone | _____ | Name all the colors | _____ | Ride a tricycle | _____ |
| Speak a few words | _____ | Begin toilet training | _____ | Ride a bicycle | _____ |
| Drink from a cup | _____ | Complete day toilet training | _____ | Begin puberty (or periods) | _____ |
| Get dressed alone | _____ | Always dry at night | _____ | Dominant handedness (R or L) | _____ |

Do you consider your child to understand directions and situations as well as other children his or her age? If no, why?

Has either parent lived apart from the child for any period of time? If so, when and for how long?

Has your child ever been hospitalized or had any serious medical problems? If so, please give details

Date of last complete physical examination

Has your child ever had the following problems, and does he/she still have them?

| | CURRENT | | CURRENT | | | CURRENT | | CURRENT | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO | | YES | NO | YES | NO | | | | | |
| Feeding problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fears and phobias | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Use of drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleeping problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loneliness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nightmares | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stealing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequently tense | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bedwetting after 4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Aggressiveness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequently sad | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thumbsucking after 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Few or no friends | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Speech problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Soiling pants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult to control | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Overactivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rocking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Destructiveness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headbanging | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor attention span | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Impulsiveness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Distractability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cries easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Underactivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Temper outbursts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low frustration threshold | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |

Has any family member ever consulted a psychiatrist, psychologist, or mental health clinic before? If so, please indicate who, when, and for what reason(s).

QUESTIONS TO BE ANSWERED BY THE SPONSOR OF THE CHILD

| | | | |
|----------------|-----------------------|------------------|-----------------|
| PLACE OF BIRTH | WHERE DID YOU GROW UP | AGES OF BROTHERS | AGES OF SISTERS |
|----------------|-----------------------|------------------|-----------------|

| | |
|-----------------------------------|--|
| HIGHEST GRADE COMPLETED IN SCHOOL | SCHOOL PROBLEMS (LEARNING, SPEECH, BEHAVIOR) |
|-----------------------------------|--|

What are your feelings about your parents and your childhood?

| | | |
|---|---|---|
| HOW LONG HAVE YOU BEEN IN THE MILITARY? | IF NOT IN THE MILITARY NOW, WHEN DID YOU LEAVE? | WHAT ARE YOUR FUTURE CAREER AND/OR EDUCATIONAL PLANS? |
|---|---|---|

Family history of medical problems, neurologic disease, or mental disorder.

List all changes of duty station and dates since the birth of this child.

QUESTIONS TO BE ANSWERED BY THE SPOUSE OF THE SPONSOR

| | | | |
|----------------|-----------------------|------------------|-----------------|
| PLACE OF BIRTH | WHERE DID YOU GROW UP | AGES OF BROTHERS | AGES OF SISTERS |
|----------------|-----------------------|------------------|-----------------|

| | |
|-----------------------------------|--|
| HIGHEST GRADE COMPLETED IN SCHOOL | SCHOOL PROBLEMS (LEARNING, SPEECH, BEHAVIOR) |
|-----------------------------------|--|

What are your feelings about your parents and your childhood?

Family history of medical problems, neurologic disease, or mental disorder.

What are your future career and/or educational plans?

QUESTIONS TO BE ANSWERED BY BOTH PARENTS

How would you describe your marriage?

Are there any unusual stressors on the family or your child?

Any previous marriages? If yes, which parent(s)?

What type of discipline do you use for your child(ren) and how does it work?

What are your future hopes and plans for your family?

How will you explain to your child that you are bringing him/her to see a doctor?

Additional remarks or comments:

SIGNATURE OF FATHER

SIGNATURE OF MOTHER