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Parent Questionnaire – Minor Intake Form

Name of Minor: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Your Name: _____ DOB: _____ Age: _____

Relationship to Minor: _____

Address if different from minor's: _____

Please Circle: Married Single Divorced Widowed Other _____

Name of Other Parent: _____ DOB: _____ Age: _____

Address if different from minor's: _____

Please Circle: Married Single Divorced Widowed Other _____

Please identify all children and adults living with the minor:

<u>Name</u>	<u>Relationship to minor</u>	<u>Age</u>	<u>Compatibility w/ minor</u> (poor, fair, good)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your minor adopted? Yes _____ No _____

If yes, please describe what you know about your minor's family of origin. (Was there a history of substance abuse; physical, sexual, emotional/neglect abuse; other foster/adoptive placements; etc.?)

If parents are not married, what are the custody arrangements (joint, legal, sole) and visitation schedule?

If applicable, please describe your current relationship with your ex-partner: _____

If applicable, how do you believe your divorce/separation/break-up has affected your minor? How old was your minor at the time?

Minor's General Health

Present condition of your minor's health (circle one): Poor Fair Good

Date of minor's last visit to the doctor and for what purpose: _____

Identify health problems of minor (circle those that apply):

Epilepsy

Ear Problems

Fainting Spells

Eye Problems

Head Injury

Diabetes

Spine Injury

Loss of Consciousness

Other: _____

Does your minor use? Glasses _____ Hearing Aid _____

Please list all medications and the dosages that your minor is currently taking or has taken in the past:

Please list all your minor's hospitalizations or surgeries and the date: _____

Does your minor have problems related to nervousness or tension? Yes _____ No _____

If yes, please explain:

Has your minor ever been involved in professional counseling before? Yes _____ No _____

If yes, please list dates and with whom. Also, include any specific diagnosis given by the therapist.

We may want to contact previous therapists. In order to do so, you will need to sign a Release of Information at our request.

History of Behavior

Please be as detailed and concise as you can. Include the age and date (exact or approx.) when possible. If you need additional space, you may use additional paper.

Developmental History:

Problems during pregnancy and birth (maternal illness; medication; alcohol or drugs during pregnancy; planned/unplanned pregnancy; complications during birth; pre-mature; low birth weight).

Developmental Landmarks: Please list the age

Walking:_____ Talking:_____ Sat Up:_____ Begin Potty Training:_____

Were there any developmental delays? Yes _____ No _____

If yes, please explain:

Any other problems? _____

Childhood Trauma (falls, injuries, accidents, seizures, illnesses which may have affected the developmental process):

Sleep Cycle (regular, irregular, nightmares, sleep terrors, bed wetting): Please indicate age. _____

Describe your experiences with your minor as a toddler: _____

Did your minor attend preschool? Yes _____ No _____

Does your minor have a history of enuresis (urinating) or encopresis (feces) problems? Yes_____No_____

If yes, please explain:

Does your minor have a history of fire setting? Yes_____ No_____

If yes, please explain:

Has your minor ever been aggressive towards animals, property, adults, or children? Yes_____ No_____

If yes, please explain:

Does your minor have a history of sexually inappropriate behavior? Yes_____ No_____

If yes, please explain:

Has your minor ever been involved in the legal system? Yes_____ No_____

If yes, please explain when, what for, and the consequences:

Presenting Problem: What behaviors or problems are you most concerned about? _____

How long has this been a problem and what were the factors leading up to your concern? _____

How does this problem affect your minor's/family's daily life? _____

How do you currently discipline your minor? For what behaviors? _____

What has worked? What has not worked? _____

History of Education

What grade is your minor in? _____ School Name: _____

Has your minor ever been in special education classes or have any learning difficulties? Yes _____ No _____
If yes, please explain:

Is there any history of learning difficulties on either side of the family? Yes _____ No _____
If yes, please explain:

School Adjustment (academic difficulties, social or behavioral adjustment, peer relationships, hyperactivity, fighting, concerns from teachers):

How is your minor doing academically? (grades, best subject, most difficulty, least favorite, etc.)

How involved do you consider yourself to be with your minor's education? _____

Social History

Please list your minor's hobbies and interests: _____

Please list your minor's positive qualities/skills: _____

What hopes do you have for your minor as he/she grows up? _____

Does your minor have any close friends? Yes _____ No _____

Does your minor have or has he/she had a girlfriend/boyfriend? (Please indicate name and age.)

List current problems with peers: _____

History of Substance Use

Does your minor have a history of substance use or abuse? Yes _____ No _____

If yes, please describe what substance(s) and frequency of use. Also, whether or not your minor received treatment for this problem:

Is your minor currently using substances? Do you suspect use of substances? Yes _____ No _____

If yes, please explain:

Does either parent or the parent's family have a history of substance abuse? Yes _____ No _____

If yes, please explain: (Indicate when, what substance, and whether or not treatment was received.)

Parent Section

Number of marriages and the length of each marriage? (If applicable, for each parent)

Mother: _____

Father: _____

If previously married, why did the relationship(s) dissolve?

Mother: _____

Father: _____

Is there a history of major mental illness/suicide/psychiatric hospitalizations in either parent's family?

What is your occupation?

Mother: _____

Father: _____

Approximately how many hours a week does each parent work?

Mother: _____

Father: _____

Describe your social interactions (with whom, where, how often): _____

What is the frequency of your alcohol use?

Mother: _____

Father: _____

Has either parent received psychotherapy in the past? Yes_____ No_____

If yes, please explain: (When, how long, and for what purpose? Was it helpful?)

Is either parent on medication? Yes_____ No_____

If yes, please explain:
