PARENT/GUARDIAN FORMS

Please check any of the following that are **typical** for child/adolescent *in the last 6 months*:

- ☐affectionate
- ☐aggressive
- ☐alcohol problems
- ☐angry
- ☐anxiety
- ☐avoids adults
- ☐bedwetting
- ☐blinking, jerking
- ☐bullies, threatens
- ☐careless, reckless
- ☐cooperative
- ☐cyber addiction
- ☐defiant
- ☐depression
- ☐destructive
- ☐talks back
- ☐teeth grinding
- ☐thumb sucking
- ☐difficulty speaking
- ☐fearful
- ☐frustrated
- ☐easily generous
- ☐head banging
- ☐hopelessness
- ☐hurts animals
- ☐impulsive
- ☐irritable
- ☐learning problems
- ☐lies frequently
- ☐listens to reason
- ☐messy
- ☐moody
- ☐nightmares
- ☐tics or twitching
- ☐unsafe behaviors
- ☐worries excessively
- ☐obedient
- ☐oppositional
- ☐quarrels
- ☐sad
- ☐selfish
- ☐separation anxiety
- ☐sets fires
- ☐sexual acting out
- ☐shy, timid
- ☐sleeping problems
- ☐soiling
- ☐steals
- ☐stomach aches
- ☐suicidal attempts
- ☐suicidal threats
- ☐other
- ☐other______________________

Please answer questions on following page~

1. Please describe any of the above (or other) concerns:

2. Have any of the above been addressed with the family doctor, if so what date?

3. How are problem behaviors generally handled?

4. What does the child/adolescent do with unstructured time?

5. Has the child/adolescent experience death? (friends, family, pets, other) _____yes _____no

If yes, describe the reaction:

6. Have there been any other significant changes or evens in your child's life (family, moving, fire, etc)
____yes _____no

If yes, please describe:

7. Any additional information that you believe would assist us in understanding your child/adolescent?

8. What are *at least 2* of your goals for the child's therapy?

9. What family involvement would you like to see in the therapy?

10. Do you think the child is suicidal at this time? _____yes ______no

If yes, please explain