



PARENT EVALUATION OF FAMILY/CHILD

Name of Child: _____ Date: _____

Name of Person Completing Form: _____

Current Concerns (What are the main reasons you are seeking help?)

	Primary Issue	Important Issue
Personal/Emotional Issues	<input type="checkbox"/>	<input type="checkbox"/>
Family Relationships	<input type="checkbox"/>	<input type="checkbox"/>
School Problems/Grades	<input type="checkbox"/>	<input type="checkbox"/>
Parent Marital Issues	<input type="checkbox"/>	<input type="checkbox"/>
Child/Parenting Concerns	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/>
Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Life Stressors	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

How long have these problems been going on? _____

What have you done to address these problems? _____

What do you think is causing these problems? _____

Have you/your family or client experienced any major life changes in the past few months? _____

Who lives in child's household?

Name	Age	Relationship to Child

Siblings?

Previous or current therapy, counseling, EAP or substance abuse treatment:

- Individual therapy
- Group therapy
- Medication management/psychiatrist
- Family therapy
- 12-step program
- Pastoral/religious

Date(s)	Reason	Where

Child's Symptom Checklist

Please check (☑) near all that apply to how you have been feeling.

Sleep problems	Memory problems	Hard time sitting still/restless
Not enjoying things	Loss of time	Worrying a lot
Problems at work	Racing heart	Drug/alcohol use
Perseverating/obsessive thoughts	Nervous or tense/unable to relax	Concerns about sexual feelings or identity
Lack of friends	Relationship problems	Other sexual concerns
Stomach aches/digestive problems	Shy/uncomfortable around others	Not feeling confident
Feeling panic or fear	Problems concentrating	Racing thoughts
Feeling anxious	Grief or loss	Problem eating habits
Not feeling good enough	Feeling hopeless	Feeling worthless
Compulsive behaviors	Disturbing thoughts	Not getting along with others
Wanting to hurt self	Mood swings	Shaking/trembling
Wanting to harm others	Feelings of wanting to die	Chronic pain
Aggressive/abusive	Sadness or depression	Childhood issues
Angry easily or a lot	Confused thinking	Problem staying on task
Problems with sexual thoughts/behavior	Problems with decision making/judgement	Concerns about family members
Irritable	Abused by others	Illegal behavior
Isolating/not wanting to be around others	Do things without thinking/impulsive	See or hear things others don't
Self harm behaviors	Disorganized thoughts	Weight concerns
Concerns about gender	Feeling helpless	Other addictive behavior

Any other symptoms/concerns that your child is experiencing not listed above: _____

Parent Work History

Parents' current employment status:

- | | |
|--|--|
| <input type="checkbox"/> Employed, full-time | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed, part-time | <input type="checkbox"/> Student |
| <input type="checkbox"/> Self employed | <input type="checkbox"/> Homemaker/stay at home parent |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Other(specify)_____ |

Job satisfaction:

- Very satisfied Moderately satisfied Not satisfied at all

Family & Extended Family Relationships

What are your [parents'] relationships with family & extended family members (close, with whom, how often visit, etc)? _____

What is child's relationships with family & extended family (close, with whom, how often visit, etc)?

Parent/Family Problem History

Is there a family history of any of these issues? (check all that apply)

- Substance Abuse Mental Illness Suicide

Name	Relationship to Client	Problem

Did you [parent] experience any of the following as a child/young adult?

- | | | | |
|---------------------------|------------------------------|-----------------------------|-----------|
| School problems: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age _____ |
| Depression: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age _____ |
| Substance abuse: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age _____ |
| Legal problems: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age _____ |
| Sexual or physical abuse: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age _____ |
| Domestic violence: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age _____ |

Did you experience any other major childhood issues? Yes No
 Describe _____

Family Treatment History

List hospitalizations for medical, psychiatric or chemical dependency problems for family members.

Who	Date(s)	Reason

Previous or current therapy, counseling, EAP or substance abuse treatment:

- Individual therapy
- Group therapy
- Medication management/psychiatrist
- Marital/couples therapy
- 12-step program
- Pastoral/religious

Who	When	Reason sought treatment	Where

Additional Information I Should Know

Please write down any other information that would be helpful for me to know about the problems or situation (including family/school, etc situations that might be contributing to child's problems & possible obstacles to making things better).

What do you want to accomplish in treatment/What goals do you have?
