Dr. Skipper
Licensed Clinical Psychologist

Parent Questionnaire

125 Indiantown Road, Suite 203-A, Jupiter, Florida 33458

NOTE: Please print and bring this completed form to your first appointment. Your cooperation in completing this questionnaire will be helpful in planning services for your child/family. Please fill out each item carefully or ask for clarification at the initial session if you do not understand an item.

Child's Name: _____

Parent Name (s):_____

Date: _____

Briefly describe your reason for seeking help:

Who referred you to Dr. Skipper?

Early childhood:

Where was your child born?

Has the family lived anywhere other than present location?

Pre/peri-natal history:

Were developmental milestones met on time? If no, explain:

Has your child suffered from any past/present medical conditions or illnesses?

Has your child suffered any injuries that required medical attention?

Has your child been a victim of or witnessed a traumatic event (sexual abuse, physical abuse, etc.)?

Family:

Are you employed? If so, where and how long?

Is your child employed? If so, where and how long?

Are you married? If yes, how long? Is your spouse your child's biological parent?

Any prior relationships or marriages?

Number of children in the home/ages:

Do you have any children who do not live in the home?

Describe your child's relationship with you/significant adults:

Describe your child's relationship with siblings:

Is there a history of family mental illness? If yes, describe diagnosis, duration, and family member:

Is there a family history of alcohol/drug use? If yes, please explain:

Is there a history of family involvement with Florida Department of Children and Families (DCF)? If yes, explain:

Is there a time that your child did not live with you? If yes, explain:

Is there a history of arguments/domestic violence in the home? If yes, explain:

Have the police ever been called to the home? If yes, explain:

Has your child ever been arrested? If yes, note circumstances/# of times/type of charges/dates:

Does your child have a history of substance use or exposure to drugs or alcohol? If yes note type of substance/age of 1st use/last use:

School:

Grade and school that your child attends:

Has your child repeated a grade? If yes, explain:

What is your child's favorite subject?

What is your child's least favorite subject?

Is your child enrolled in any special classes (gifted, ESE)?

Describe your child's overall academic performance:

Describe your child's behavior when at school:

Has your child ever received a suspension or been expelled? If yes, explain:

Peer Relationships:

Describe your child's friendships/relationships with peers (duration, quality, difficulties, etc.):

How long do friendships typically last?

What does your child like to do when he/she has unstructured time? Is he/she involved in community activities/youth group?

Mood Symptoms:

Has your child experienced any of the following to the point that you were concerned or an area of functioning (social, emotional, behavioral) was negatively affected? If yes, explain:

Depressed mood:

Sad or Irritable:

Fatigue/loss of energy:

Guilt/fears:

Sleeping/eating/weight loss or gain:

Manic symptoms (rapid speech, racing thoughts, risky behavior, etc.):

Nervousness/frequent indecisiveness:

Has your child experienced the following? If yes, explain in detail:

Thoughts of suicide or a suicide attempt:

Thoughts of harming another or actual harm of another:

History of self-injury:

Thoughts:

Has your child experienced any of the following? If yes, explain:

Hallucinations (feeling bodily sensations, hearing sounds, hearing voices, seeing object that no one else sees, etc.):

Delusions (ideas that seem real but are not based on reality):

Bizarre/inappropriate behavior:

Dissociation:

Has your child experienced any of the following? If yes, explain:

Spacing out/gaze off as though in a trance:

Depersonalization/Not feeling real:

Imaginary friends:

Behavior/Conduct/Oppositional:

Has your child experienced any of the following to the point that you were concerned? If yes, explain.

Aggression:

Defiance:

Attention/concentration difficulties:

Treatment History:

Has your child received therapeutic services in the past? If yes, dates/treating clinician's name/city, state:

Is your child currently prescribed medication? If yes, dates/treating clinician's name/city, state:

Has your child ever undergone any educational, social, emotional, or cognitive testing? If yes, evaluator's name/dates of testing/location:

Has your child experienced the death or loss of a close relationship or family pet in the past year?

How do you deal with inappropriate behavior in the home?

Discipline methods:

Successful?

Biggest concern with your child?

What are your child's strengths?