

ALPHA OMEGA CLINIC AND CONSULTATION SERVICES

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SUPPLEMENTAL PARENT QUESTIONNAIRE

Name: _____

Date: _____

This questionnaire addresses your child or adolescent's past and present development. Your viewpoints on these items will provide invaluable information to allow us to better help your child.

1. Pregnancy, delivery and development:

- a. Were there any stresses during the pregnancy or the first two years after your child's birth (relocations, marital problems, deaths, financial problems employment issues, health issues)

No

Yes (if yes, please comment)

- b. Were there any difficulties with your child's developmental milestones (crawling, walking, toilet training, coordination, etc.)

No

Yes (if yes, please comment)

- c. How would you describe your relationship with your son/daughter as an infant, preschooler, grade school, and adolescent?

- d. Describe any mental health problems in the family

2. Medical History

- a. Has your child experienced any unusual medical problems (broken bones, head injury, coma, surgery, accidents, etc.)?

No Yes (if yes, please comment)

- b. Is your child on medication?

No Yes (if yes, please comment)

- c. Is there any family history (to include grandparents, aunts, uncles, etc.) of medical problems (to include depression, anxiety problems, mental illness, or substance abuse)?

No Yes (if yes, please comment)

3. Family Environment

- a. Please describe current family rules and how well your child complies with them. What do you do when he or she doesn't comply?

- b. How would you describe your child's activity and focus on the faith?

4. Adolescence

- a. Describe your teen's academic performance (past and present)

b. Has your teen ever been in special education programs, evaluated by school psychologists or learning disability specialists?

c. Is your teenager dating (frequency or seriousness)

No Yes (if yes, please comment)

d. Describe your teen's relationship with peers.

e. Has your teen ever had any legal or criminal problems?

No Yes (if yes, please comment)

f. Has your teen ever threatened or attempted to run away, commit suicide, or harm another family member?

No Yes (if yes, please comment)

g. Does your teenager use alcohol, cigarettes, or other drugs and to what extent?

No Yes (if yes, please comment)

h. Has your teenager engaged in sexual activity?

No Yes (if yes, please comment)

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- i. Has your child ever been in counseling before?
 No Yes (if yes, please comment)

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- j. Any additional comments that would help us to know your child better?
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5. Parenting Checklist

- a. Do you and your spouse frequently disagree or argue about your child's behavior?
Mother: yes ____ no ____
Father: yes ____ no ____
- b. Do you often worry about your child's problems?
Mother: yes ____ no ____
Father: yes ____ no ____
- c. Do you find yourself trying to cover up or make excuses for your child's behavior?
Mother: yes ____ no ____
Father: yes ____ no ____
- d. Do you ever feel that no matter how hard you try, you can't seem to change your child's behavior?
Mother: yes ____ no ____
Father: yes ____ no ____
- e. Have you made some changes in your behavior with the hope of changing his or hers?
Mother: yes ____ no ____
Father: yes ____ no ____
- f. Do you often feel angry or have a dislike of your child?
Mother: yes ____ no ____
Father: yes ____ no ____
- g. Do you think your child misbehaves because he is bad, or because he has an emotional problem?
Mother: bad ____ emotional problem ____
Father: bad ____ emotional problem ____
- h. Do you fear that your child might injure himself or herself or others?
Mother: yes ____ no ____
Father: yes ____ no ____
- i. Do you find yourself wanting to spend less time at home to avoid conflicts with your child?
Mother: yes ____ no ____
Father: yes ____ no ____