Client ID#: _____
Last Name: _____
Date Scanned to EHR: ___/___/____
Scanned by: _____

Provident
to a brighter future

Administrative Office ● 2650 Olive Street ● Saint Louis, Missouri 63103 ● 314-371-6500

Parent Questionnaire

Child's Name: _____ Age: _____ Home Phone: _____
First, Middle, and Last Name

Nicknames: _____ Parent's Work Phone: _____

Street Address: _____ Cell/Other #: _____

Apt #: _____ Date of Birth: _____ Email: _____

City: _____ State: _____ Social Security #: _____-_____-_____

Zip Code: _____ Child's Gender: ☐ Male ☐ Female ☐ Other: _____

Race/Ethnicity: ☐ African American ☐ Caucasian ☐ Asian ☐ Native American/Alaskan Native
☐ Hispanic/Latino ☐ Biracial/Multiracial ☐ Other: _____

Child's Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Questioning

Who referred you to Provident? _____

PRESENTING CONCERNS

What problems or concerns bring you and your child to Provident today? (Include when problem began, how often, triggers, etc.)

_____

_____

What do you hope to accomplish through counseling?

_____

_____

FAMILY INFORMATION

Child's Mother: _____ **Child's Father:** _____

Date of Birth: ____/____/_____ Date of Birth: ____/____/_____

Education: _____ Education: _____

Occupation: _____ Occupation: _____

Marital Status of Child's Parents (select all that apply):
☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Living Together
☐ Mother Remarried ☐ Father Remarried ☐ Parent Deceased ☐ Other: _____

If parents are divorced or separated:

Who has legal custody? _____ Who has financial responsibility? _____

Is there court mandated child support? ☐ Yes ☐ No If yes, is it paid regularly? ☐ Yes ☐ No

Do You Live In an: ☐ Apartment ☐ House ☐ Other: _____ Do you: ☐ Rent ☐ Own

Annual Family/Household Income: $_____

Do you use assistance to pay utility bills or other expenses? ☐ Yes ☐ No If yes, explain: _____

Is there enough food and clothing in the household? ☐ Yes ☐ No

What is your living situation? ☐ Stable ☐ Unstable ☐ Homeless ☐ Dangerous or Hazardous

Total # of people living in the household: _____

FAMILY INFORMATION (cont.)

With whom does your child live?

Name of Household Member	Age	Relationship to Child

SCHOOL HISTORY

Child's School: _____ Grade: _____ Teacher: _____

Is your child attending: ☐ Regular Classroom ☐ Regular Class & Resource Room ☐ Learning Disabilities Classroom ☐ Special Class ☐ Behavior Disabilities Classroom ☐ Other: _____

Has your child ever been suspended from school? ☐ Yes ☐ No ☐ Once ☐ Infrequently ☐ Frequently

Has the child ever changed schools or school districts? ☐ Yes ☐ No If Yes, why? _____

Has your child had an Individualized Education Program (IEP)? ☐ Yes ☐ No If Yes, when? _____

Has your child ever repeated a grade? ☐ Yes ☐ No If Yes, what grade(s)? _____

Has your child been attending school regularly? ☐ Yes ☐ No If No, why? _____

Has your child ever been fearful or reluctant to attend school? ☐ Yes ☐ No If Yes, when? _____

Does your child complete his or her homework regularly? ☐ Yes ☐ No

Does your child require help completing homework? ☐ Yes ☐ No

Does your child have behavior or academic problems at school? ☐ Yes ☐ No

If Yes, explain: _____

_____

WORK HISTORY

Does your child have a job? ☐ Yes ☐ No

If Yes: Job Title: _____ Employer: _____ Hours Worked Weekly: ____

PEER RELATIONSHIPS

Does your child seek friendships? ☐ Yes ☐ No

Is your child sought by peers for friendships? ☐ Yes ☐ No

Does your child play with children his or her own age? ☐ Yes ☐ No ☐ Younger ☐ Older

Is your child having problems with friends or in social situations? ☐ Yes ☐ No

If Yes, explain: _____

My child's support system includes: ☐ Many friends and family ☐ few friends or family ☐ no support system

HOME BEHAVIOR

Who ordinarily disciplines your child? ☐ Mother ☐ Father ☐ Both Parents ☐ Other: _____

What techniques do you use to discipline your child? _____

Have these methods been effective? ☐ Yes ☐ No

How well does your child get along with his or her brothers and sisters?
☐ Very Well ☐ Average ☐ Arguments ☐ Avoids ☐ Frequent Fights ☐ Jealousy ☐ Is Teased ☐ Teases

Does your child share a bedroom? ☐ Yes ☐ No If yes, with whom? _____

Does your child experience any sleep problems (ex. difficulty falling or staying asleep, problematic dreams)? ☐ Yes ☐ No
If Yes, explain: _____

Has your child had any changes in appetite? ☐ Yes ☐ No
If Yes, explain: _____

Has your child had any frightening or traumatic experiences? ☐ Yes ☐ No
If Yes, explain: _____

Have you ever been involved with Children's Services (DFS, DCFS, Children's Division)? ☐ Yes ☐ No
If Yes, explain: _____

Has anyone been physically or sexually abusive to your child? ☐ Yes ☐ No
If Yes, please describe _____

Has your child witnessed physical or sexual violence? ☐ Yes ☐ No
If Yes, please describe: _____

LEGAL HISTORY

Has your child ever been arrested? ☐ Yes ☐ No
If Yes, why? _____

Has your child ever been convicted of a crime? ☐ Yes ☐ No
If Yes, what was the charge(s)? _____

Is your child under court supervision or required to meet with a Juvenile Officer (DJO)? ☐ Yes ☐ No

SUBSTANCE USE HISTORY

Does your child smoke cigarettes? ☐ Yes ☐ No If Yes, how much/how often? _____

To your knowledge, has your child ever used alcohol or drugs? ☐ Yes ☐ No

If Yes, please describe (include substance is used & how often): _____
_____

MENTAL HEALTH HISTORY

Has your child had previous counseling, psychotherapy, or psychiatric care? ☐ Yes ☐ No

If Yes, describe past treatment dates, services received, medications prescribed, & previous diagnoses.
_____
_____

What traumatic or difficult events has your child experienced? _____
_____

Have any immediate family members experienced mental health issues or participated in treatment? ☐ Yes ☐ No

If Yes, please describe relation to child, diagnosis/problem, and any treatment received.
_____
_____

ADDITIONAL HISTORY

What activities/hobbies/interests does your child enjoy? _____

Who does your child depend upon for emotional support? _____

Does your child use community resources or self-help groups? _____

What is your child's religious background? _____

Is your child active in these spiritual practices? ☐ Yes ☐ No

Provident
to a brighter future
Administrative Office ● 2650 Olive Street ● Saint Louis, Missouri 63103 ● 314-371-6500

MEDICAL HISTORY

Child's Current Height: _____ Current Weight: _____ Date of Last Exam: ____/____/_____

Primary Care Physician: _____ Telephone #: _____

Length of Pregnancy: ☐ Full Term ☐ Premature (____ weeks)

Complications, illness or accidents during pregnancy, birth, or infancy? ☐ Yes ☐ No
If Yes, explain: _____

Alcohol or drug use during pregnancy? ☐ Yes ☐ No

Were developmental milestones (sitting, walking, talking, potty training): ☐ Early ☐ Normal ☐ Late
Describe skills developed late or early: _____

Indicate which of the following medical conditions ***currently*** affect your child:

☐ Acid Reflux	☐ Allergies	☐ Asthma	☐ Autoimmune Disorder	☐ Birth Defects
☐ Cancer	☐ Chest Pain/Pressure	☐ Chronic Pain	☐ Constipation	☐ Cough
☐ Diabetes	☐ Diarrhea	☐ Difficulty Breathing	☐ Difficulty Speaking	☐ Difficulty Swallowing
☐ Dizziness/Vertigo	☐ Ear Pain	☐ Eating Disorder	☐ Epilepsy/Seizures	☐ Fatigue
☐ Fever/Chills/Sweats	☐ Eye Pain	☐ Glaucoma	☐ Headaches/Migraines	☐ Hearing Loss
☐ Heart Disease	☐ Heart Attack	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney Problems	☐ Kidney Disease/Dialysis	☐ Liver Problems	☐ Loss of Appetite	☐ Menstrual Problems
☐ Nasal Congestion	☐ Pregnancy	☐ Shortness of Breath	☐ Sickle Cell	☐ Sleeping Problems
☐ Stomach Pain/Problems	☐ Stroke	☐ Thyroid Disorder	☐ Traumatic Brain Injury	☐ Urinary Problems
☐ Vision Problems	☐ Vomiting	☐ Weight Change (loss/gain)	☐ Difficulty Walking/Coordinating Movements	

☐ Other: _____

Is your child currently being treated for the medical conditions listed above? ☐ Yes ☐ No

Describe any history of serious medical conditions, illnesses, or surgeries: _____

Please list any allergies your child has (food, medication, seasonal, etc.): _____

Is your child current with immunizations? ☐ Yes ☐ No If No, explain: _____

Current Medications: Please list all prescriptions, over the counter medications, and supplements your child is currently taking.*

Medication Name	Dosage/Frequency	Start Date	Prescribing Physician	Side Effects

Does your child take the medicine as prescribed? ☐ Yes ☐ No *attach medication list, if needed

Nutritional Screen	YES	NO
My child has an illness or condition that made me change the kind and/or amount of food they eat.	☐ Yes	☐ No
My child eats fewer than 2 meals per day.	☐ Yes	☐ No
My child eats TOO FEW fruits or vegetables or milk products.	☐ Yes	☐ No
My child has tooth or mouth problems that make it hard for them to eat.	☐ Yes	☐ No
My child doesn't always have enough money to buy the food they need.	☐ Yes	☐ No
My child takes 3 or more different prescribed or over-the-counter drugs a day.	☐ Yes	☐ No
My child, without wanting to, has lost or gained 10 pounds in the last 6 months.	☐ Yes	☐ No

On a scale of 1 to 10, what is the present level of **physical** pain your child is experiencing?

0	1	2	3	4	5	6	7	8	9	10
No Pain									**Extreme Pain**	

Specify Location of Pain: ☐ Muscular ☐ Joint ☐ Neck ☐ Back ☐ Other: _____

Does the pain your child experiences affect his/her daily activities? ☐ Yes ☐ No

Provident
to a brighter future
Administrative Office ● 2650 Olive Street ● Saint Louis, Missouri 63103 ● 314-371-6500

Pediatric Symptom Checklist (PSC) – Parent Version

Child's Name: _____ Completed by: _____ Date: _____

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total Score: _____