Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Parent Questionnaire

Child's Legal Name: ___________________________ Birth Date: ___/___/______ Age: ____ Sex at Birth: ☐ Male ☐ Female

Nickname/Chosen Name: ______________________ Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other: _______________

Address: ____________________________ Apt #: ______ City: _____________________ State: _______ Zip: ___________

Home Phone: ______-______-________ Cell Phone: ______-______-________ Email: ______________________________

Race/Ethnicity: ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ Biracial/Multiracial
☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Other/Describe: ___________________________

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

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 treatment? ____

____

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: ______

With whom does your child live?

Name of Household Member	Age	Relationship to Child

Provident Behavioral Health

Client Name: ___________________
DOB: ___/___/_____
Date Completed: ___/___/_____

SCHOOL HISTORY

Child's School: ________________________________ Grade: ________ Teacher: ___________________________

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

Client Name: ________________
DOB: ___/___/____
Date Completed: ___/___/____

Has your child had any frightening or traumatic experiences *(including accidents, losses, abuse, neglect, or exploitation)*? ☐ Yes ☐ No

If Yes, explain: ____________________

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

If Yes, explain: ____________________ ☐ Currently Involved

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 any religious or spiritual practices? ☐ Yes ☐ No Describe: ____________________

Client Name: ________________
DOB: ___/___/____
Date Completed: ___/___/____

MEDICAL HISTORY

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

Primary Care Physician: ________________________________ Telephone #: ____________________

Length of Pregnancy: ☐ Full Term ☐ Premature (____ weeks) Alcohol/drug use during pregnancy? ☐ Yes ☐ No

Complications, illness or accidents during pregnancy, birth, or infancy? ☐ Yes ☐ No

If Yes, explain: ____

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

Pain Screen: On a scale of 1 to 10, what is the present level of **physical** pain your child is experiencing? *(circle one)*

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

Location of Pain: ☐ Muscular ☐ Joint ☐ Neck ☐ Back ☐ Other: ______
Does your child's pain affect his/her daily activities? ☐ Yes ☐ No

Nutrition Screen: *Please answer the following about your child's nutritional habits. Please explain any items marked "yes".*

Yes	No	My child…	Explanation:
1	0	1. Has had a decreased appetite/has been eating less than normal.	Decreased appetite has lasted for: ____ **(#) days/weeks/months**
1	0	2. Has lost or gained at least 10 pounds in the last **3** months.	______ pounds ☐ gained ☐ lost
1	0	3. Has an allergy, illness, or condition impacts how they eat.	Explain:
1	0	4. Requires a special diet.	Explain why special diet is needed and if child adheres to diet:
1	0	5. Has dental problems that make it hard to eat.*	Describe tooth or mouth pain/problems:
1	0	6. Eats fewer than 2 meals per day.	
1	0	7. Eats too few fruits or vegetables or milk products.	
1	0	8. Our family does not always have enough money to buy the food our child needs.**	
1	0	9. Has been binge eating (eating large quantities of food at once).	
1	0	10. Has been forcing himself/herself to vomit after eating.	
1	0	11. Has been excessively active to burn off calories consumed.	
1	0	12. Has been concerned with weight and/or restricting calories.	
Total Score:		**Score Interpretation:** Scores of 4-7 = use clinical judgement to determine referral needs. Scores of 8+ = refer to doctor, nutritionist, or other appropriate resource(s). *Refer to dental care if dental problems are noted. **Refer to resources for food if family needs assistance.	

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Provident Behavioral Health

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: _______