

Tahoe Youth & Family Services

(Babies & Young Children 0-9 years)

PARENT/GUARDIAN CONFIDENTIAL QUESTIONNAIRE

Today's Date: ____ / ____ / ____

Client #: _____

Client (Child's) Name: _____ Age: _____ SS#: _____

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

Parents Information: Mother/Guardian/Step/Foster:

Client's Mother: _____ Age: _____

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

Street Address: _____

Mailing Address: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Ethnicity/Race: _____ Marital Status: _____ Can we leave message?

Last Grade Completed: _____ Diploma/Degree: _____ Home Cell Work

Disability: _____

Children:

Name: _____ Date of Birth: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Name: _____ Date of Birth: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Name: _____ Date of Birth: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Name: _____ Date of Birth: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Parent Information: Father/Guardian/Step/Foster:

Client's Father: _____ Age: _____

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

Street Address: _____

Mailing Address: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Ethnicity/Race: _____ Marital Status: _____ Can we leave message?

Last Grade Completed: _____ Diploma/Degree: _____ Home Cell Work

Disability: _____

Children:

Name: _____ Date of Birth: ____ / ____ / ____ Ethnicity: _____ Disability: _____

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Name: _____ Date of Birth: ____ / ____ / ____ Ethnicity: _____ Disability: _____

The following questions will allow us to find out more about the problems you are dealing with. By giving these questions your full attention, you will help us better assist you, and it will help you to clarify the problems you want to work on.

Please list some of the problems you are encountering being a parent.

What are some of the current behaviors of your child (or children) that concern you the most?

In what ways have you tried to solve these problems on your own?

What past events do you feel may have contributed to the current problems/concerns?

Please list three goals you would like to accomplish for you, your child, or your family.

1.

2.

3.

Specifically, what do you feel we can do to help you and your child/children accomplish these goals?

Please check all the behaviors or symptoms that you believe your child has experienced.

- | | |
|---|---|
| <input type="checkbox"/> Cries a lot | <input type="checkbox"/> Vomiting (without medical cause) |
| <input type="checkbox"/> Can't be calmed or soothed | <input type="checkbox"/> Behavior problems at school or daycare |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Difficulty getting along with others |
| <input type="checkbox"/> Wanders at night | <input type="checkbox"/> Disturbs other children |
| <input type="checkbox"/> Talks or cries in sleep | <input type="checkbox"/> Whining |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Impulse control |
| <input type="checkbox"/> Difficulty with change | <input type="checkbox"/> Defies rules |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Difficulty with right and wrong |
| <input type="checkbox"/> Fearful or anxious | <input type="checkbox"/> Resists going to bed |
| <input type="checkbox"/> Sick frequently | <input type="checkbox"/> Acts too young for age |
| <input type="checkbox"/> Rocking | <input type="checkbox"/> Doesn't know how to have fun; acts like a "little adult" |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Hits others or bites, aggression to others |
| <input type="checkbox"/> Clingy and inappropriately demanding | <input type="checkbox"/> Truant from school before age 13 |
| <input type="checkbox"/> Avoids looking others in the eye | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Daydreams or get lost in thought, stares into space | <input type="checkbox"/> Inappropriate sexual behavior |
| <input type="checkbox"/> Can't stand having things out of place | <input type="checkbox"/> Elimination problems (soiling pants, bed wetting) |
| <input type="checkbox"/> Can't stand waiting, wants everything now | <input type="checkbox"/> Preoccupation with fire, gore or evil |
| <input type="checkbox"/> Eating problems (hoarding or picky eater) | <input type="checkbox"/> Persistent nonsense questions and incessant chatter |
| <input type="checkbox"/> Fears certain animals, situations, or places other than daycare or school (describe) | <input type="checkbox"/> Speech problems |
| <hr/> | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Perceives self as victim (helpless) |
| <input type="checkbox"/> Can't sit still or is restless | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Difficulty following directions | <input type="checkbox"/> Self-mutilating |
| <input type="checkbox"/> Easily jealous | <input type="checkbox"/> Holds breath |
| <input type="checkbox"/> Unmotivated, won't play alone | <input type="checkbox"/> Cruel to animals |
| <input type="checkbox"/> Fearless | <input type="checkbox"/> Doesn't feel guilty after misbehaving |
| <input type="checkbox"/> Underactive, moves slowly or lack of energy | <input type="checkbox"/> Doesn't answer when people speak to them |
| <input type="checkbox"/> Sudden changes in mood or feeling | |

Parent Observations: Please check the following

| | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 1. The child reciprocates when smiling at them or saying hello? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Will share play objects? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Will take turns? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Will engage in pretend play with others? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Willingly follow the rules? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Uses words or gestures to communicate needs or feelings? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Shows curiosity about the environment (people & things) using words or gestures? | <input type="checkbox"/> | <input type="checkbox"/> |

Parent Observations (continued): Please check the following

| | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 8. Is comfortable with new experiences? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is comfortable when saying goodbye to caregiver? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is excited when you pick them up from sitter or continuous playing? | <input type="checkbox"/> | <input type="checkbox"/> |

Are you currently seeking services (or have you been involved with) any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Family Resource Center | <input type="checkbox"/> Private Counselor |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Sierra Recovery Center | <input type="checkbox"/> Cal Works |
| <input type="checkbox"/> Women's Center | | <input type="checkbox"/> Other: _____ |

Who referred you here?

- | | | |
|--|--|--|
| <input type="checkbox"/> School _____ | <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Family |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Sierra Recovery Center | <input type="checkbox"/> Yourself |
| <input type="checkbox"/> SARB | <input type="checkbox"/> Police Department | <input type="checkbox"/> Headstart/Early Headstart |
| <input type="checkbox"/> Women's Center | <input type="checkbox"/> Child Care Provider | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> LTUSD Expulsion Board | | |

Have any of the following situations happened in your family? If so, when?

| Situation | Year Occurred |
|---|----------------------|
| <input type="checkbox"/> Parents' divorce | _____ |
| <input type="checkbox"/> Custody battle | _____ |
| <input type="checkbox"/> Death in the family or someone close | _____ |
| <input type="checkbox"/> Hospitalization of child | _____ |
| <input type="checkbox"/> Loss of friends | _____ |
| <input type="checkbox"/> Death of pet | _____ |
| <input type="checkbox"/> Significant person leaving | _____ |
| <input type="checkbox"/> Move from house or school | _____ |

