



T A H O E
YOUTH & FAMILY
 S E R V I C E S
 A SAFETY NET OF SERVICES FOR YOUTH AND FAMILIES

**PARENT / GUARDIAN
 CONFIDENTIAL
 QUESTIONNAIRE**
To be filled out by the Parent

Today's Date: ____ / ____ / ____

Client #: _____

Medi-Cal # _____

PLEASE PRINT

Client's (Child's) Name: _____ Sex: M F Age: _____

DOB: ____ / ____ / ____ Social Security # _____ Insurance: _____

Parent's Information: Mother / Guardian / Stepmother / Foster Mother please circle one

Name: _____ Age: ____ DOB ____ / ____ / ____

Place of Birth: _____ Ethnicity/Race: _____
city state

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Ph: ____ -- ____ -- ____ Work Ph: ____ -- ____ -- ____ Cell Ph: ____ -- ____ -- ____

Can we leave a message? Yes No Home Work Cell

Marital Status: Single Married Divorced Widowed Partner Disability: _____

Last Grade Completed: _____ Diploma / Degree: _____

Children:

Name: _____ DOB: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Name: _____ DOB: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Name: _____ DOB: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Name: _____ DOB: ____ / ____ / ____ Ethnicity: _____ Disability: _____

Parent's Information: Father / Guardian / Stepfather / Foster Father please circle one

Name: _____ Age: ____ DOB ____ / ____ / ____

Place of Birth: _____ Ethnicity/Race: _____
city state

Address: _____
street city state zip

Mailing Address: _____
street city state zip

Home Ph: _____ -- _____ -- _____ Work Ph: _____ -- _____ -- _____ Cell Ph: _____ -- _____ -- _____

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The following 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 issues 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?

Are you currently seeking services from (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"/> Vitality | _____ |
| <input type="checkbox"/> Women's Center | <input type="checkbox"/> Cal works | name |

Who referred you here?

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

Please list any counselors, therapists, psychologists, psychiatrists, and/or doctors that you or your child have seen (evaluations, exams, testing).

Child	Date	Parent	Date

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

Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Sneaking out & staying out all night before the age of 13
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	Running away (how many times?_____)
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Truant from school before age 13
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Expresses severe disgust in others
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Has nightmares or flashbacks about being abused
<input type="checkbox"/>	<input type="checkbox"/>	Changes in eating patterns	<input type="checkbox"/>	<input type="checkbox"/>	Increase in aggressive behavior
<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Major increase or decrease in interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hopelessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	Anger, rage or fear towards certain people
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking
<input type="checkbox"/>	<input type="checkbox"/>	Lack of caring about anything	<input type="checkbox"/>	<input type="checkbox"/>	Baby talk
<input type="checkbox"/>	<input type="checkbox"/>	Isolation and/or trouble making or keeping friends	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	Feeling restless or nervous	<input type="checkbox"/>	<input type="checkbox"/>	Problems with sibling(s)
<input type="checkbox"/>	<input type="checkbox"/>	Having racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Problems with other significant person Who? _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worrying	<input type="checkbox"/>	<input type="checkbox"/>	Academic problems
<input type="checkbox"/>	<input type="checkbox"/>	Confused thinking or mind “going blank”	<input type="checkbox"/>	<input type="checkbox"/>	Attraction to the same sex
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding certain situations or people	<input type="checkbox"/>	<input type="checkbox"/>	Problems adapting from old culture to new
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Poor body image	<input type="checkbox"/>	<input type="checkbox"/>	Change in friends
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Drop in grades and/or extended absences or tardies
<input type="checkbox"/>	<input type="checkbox"/>	Eating very little or fasting	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-image (“I’m a loser”)
<input type="checkbox"/>	<input type="checkbox"/>	Exercising frequently	<input type="checkbox"/>	<input type="checkbox"/>	Low energy, sleeping more
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal from family and close friends
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting after eating	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations when not under the influence of drugs or alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Being “hyper”	<input type="checkbox"/>	<input type="checkbox"/>	Head injury (Date: ____/____/____)
<input type="checkbox"/>	<input type="checkbox"/>	Having difficulty paying attention	<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	<input type="checkbox"/>	Being fidgety or restless	<input type="checkbox"/>	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	<input type="checkbox"/>	Reading or learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse
<input type="checkbox"/>	<input type="checkbox"/>	Problems getting along with others	<input type="checkbox"/>	<input type="checkbox"/>	Witnessed or experienced traumatic event (car crash, earthquake, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Losing temper often	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Arguing with adults and/or refusing to obey authority figures	<input type="checkbox"/>	<input type="checkbox"/>	Feeling numb or detached (“in a daze” or “out of it”)
<input type="checkbox"/>	<input type="checkbox"/>	Often blaming others for his/her mistakes	<input type="checkbox"/>	<input type="checkbox"/>	Irritable
<input type="checkbox"/>	<input type="checkbox"/>	Overly sensitive, “touchy”, vindictive	<input type="checkbox"/>	<input type="checkbox"/>	Unable to remember or recall certain events
<input type="checkbox"/>	<input type="checkbox"/>	Initiates fights	<input type="checkbox"/>	<input type="checkbox"/>	Has access to guns or weapons
<input type="checkbox"/>	<input type="checkbox"/>	Cruel to animals or people	<input type="checkbox"/>	<input type="checkbox"/>	Steals things
<input type="checkbox"/>	<input type="checkbox"/>	Deliberately sets fire or destroys other’s property	<input type="checkbox"/>	<input type="checkbox"/>	Lies, manipulates or “cons”

Please use the space below for any additional thoughts or concerns you may have regarding your child/children
