

VIRGINIA BEACH COUNSELING SERVICES

CHILD AND ADOLESCENT PARENTAL QUESTIONNAIRE

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ School  
Contact Person: \_\_\_\_\_

Family

1) \_\_\_\_\_  
Parent Name Home Phone Work Phone

2) Members of Household (everyone living in the home)

Name	Age	Occupation	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3) Client current lives with (circle one)

Birth parents Stepparent Adoptive family Foster family

Other (describe) \_\_\_\_\_

4) Ever lived more than one month with someone other than current caretakers (circle one)

Yes No

If yes, please describe \_\_\_\_\_

School (circle one)

1) Retained in a grade: Yes No

2) Ever suspended: Yes No

Client's Name: \_\_\_\_\_

Account # \_\_\_\_\_

- 3) Ever needed special education: Yes No
- 5) Do you have any concerns that your child might have a learning disability: Yes No

Legal

- 1) Any past history of legal charges Yes No
- 2) If currently on probation, name of probation officer: \_\_\_\_\_

Family Medical History Please circle any that apply and note relationship to client

- Serious Illness \_\_\_\_\_
- Learning Disability \_\_\_\_\_
- School Problems \_\_\_\_\_
- Temper outbursts \_\_\_\_\_
- Problems with the law \_\_\_\_\_

Developmental History

- 1) Any complications with pregnancy or delivery Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 2) Milestones – anything unusual about client milestones Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 3) Any language/hearing problems Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 4) Any developmental delays Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Client's Name: \_\_\_\_\_

Account # \_\_\_\_\_

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Interests

1) Special skills or talents \_\_\_\_\_

\_\_\_\_\_

2) Special interests, sports, or hobbies \_\_\_\_\_

\_\_\_\_\_

Completed by: \_\_\_\_\_  
(please circle: Parent or Legal Guardian)

Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_  
(Clinician Signature)

Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Account # \_\_\_\_\_