

Brooke G. Dooley, LPC
Licensed Professional Counselor
1060-B Cliffwood Street
Mount Pleasant, SC 29464
Phone 843.270.8024
Fax 866.624.4986
Brooke@GiftedClients.com



**Adolescent and Family Counseling
Parent Report**

Adolescent's Demographics

Name: _____
Address: _____
Contact phone number: _____ Age: _____
School: _____ Year: _____

Parents' Demographics

Father's name: _____
Address: _____
Employer: _____
Mother's name: _____
Address: _____
Employer: _____

Alternate Contacts

Emergency contact: _____
Telephone number: _____ Relationship: _____

Family and Home Information

Persons currently living in the household:

Name	Age	M/F	Relationship
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____

Teen's Developmental and Medical History

Were there any prenatal problems during pregnancy? _____ No _____ Yes

If "yes," please explain: _____

Were there any problems during delivery? _____ No _____ Yes

If "yes," please explain: _____

Birth weight: _____ lbs _____ oz.

Infancy:

A. Were there any feeding problems? _____ No _____ Yes

If "yes," please explain: _____

B. Did your child sleep well? _____ No _____ Yes

If "no," please explain: _____

C. At what age was your child toilet trained? _____

Were there any difficulties? _____

D. Were there any speech and language difficulties? _____ No _____ Yes

Please describe: _____

Milestones

At what age did your child:

_____ Wean _____ Walk _____ Sit up alone _____ Talk

Were there any difficulties? _____

Family Medical History

Is there a history of any of the following in the family?

(Use "M" for mother's side; "F" for father's side.)

_____ ADHD/ADD

_____ Vision problems

_____ Birth defects

_____ Hearing problems

_____ Emotional problems

_____ Drug abuse

_____ Behavior problems

_____ Alcohol abuse

_____ Mental retardation

_____ Diabetes

_____ Thyroid problems

_____ Convulsions/seizures

If "other," please explain: _____

Further comments: _____

Does or did your child have allergies? ___No ___Yes

If "yes," to what does the child have allergies? _____

How severe are the reactions? _____

Are there any special precautions that need to be taken? _____

Please detail any of your child's hospitalizations:

Date	Age	Hospital	Reason	Length of stay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please detail any other medication history:

Have there been any significant family losses (deaths) during this teen's life?

Teen's School History

School attendance:

	Date	Location	Problems (Y/N)	Reason left
Preschool	_____	_____	_____	_____
Kindergarten	_____	_____	_____	_____
Grade 1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____
9	_____	_____	_____	_____
10	_____	_____	_____	_____
11	_____	_____	_____	_____
12	_____	_____	_____	_____

If answered "yes," to problems at any academic level, please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:

Typical Day Descriptions

A. How does your teen prepare him/her for the day (waking, getting ready, etc.)

B. Does the teen eat breakfast? ___No ___Yes If so, what?

C. Does the teen watch the time and leave promptly or is frequent reminding necessary?

D. What does the teen do after school?

E. What occurs at dinnertime?

1. Does the family eat together? ___No ___Yes

2. Is the teen on time? ___No ___Yes

3. Are there any problems during dinner? ___No ___Yes

If you answered “no,” to any or these questions, or “yes,” to question 3, please explain: _____

F. What occurs after dinner?

G. What does the teen do on weekends?

Friday night: _____

Saturday: _____

Sunday: _____

H. Does your family have much “family time” together?

I. What activity do you enjoy most with your teen?

J Does your teen spend time with friends?

How much time on a weekly basis? _____

How many friends does you teen have? _____

How do you feel about your teen’s friends? _____

K. Does your teen belong to any clubs, groups, or organizations?

If so, which ones: _____

L. Does your teen have any interests or hobbies?

M. Does your teen get an allowance? ___No ___Yes

If so, is it earned or given? _____

How does the teen manage the money? _____

N. Does your teen have specific chores? ___No ___Yes

If so, what are they? _____

Does your teen try to avoid doing chores? ___ No ___Yes

What does he do to try to avoid them (refuse, argue, etc.)? _____

O. What methods do you use to discipline your teen?

How often is it necessary? _____

Does it work? _____

Behavior Checklist

Check the behaviors listed below that apply to your teen within the past 6 months:

___ Is clumsy and awkward in movements.

___ Is often drowsy/tired.

___ Engages in self-destructive behaviors:

(please specify): _____

___ Has tantrums frequently.

___ Hyperactive.

___ Is distracted

___ Demands too much attention.

___ Is often sluggish or slow moving.

___ Often has physical complaints (i.e., headaches, stomachaches, etc.).

___ Usually wants to be alone.

___ Frequently disobedient.

___ Gives up easily on tasks.

___ Does not interact appropriately with:

___ Parents ___ Siblings ___ Peers ___ Others

___ Physically abuses:

___ Parents ___ Siblings ___ Peers ___ Pets

___ Cries, whines, or pouts frequently.

___ Rarely obeys requests, commands, etc.

- Talks back to parents or other authority figures.
- Reacts poorly when losing a game.
- Unreasonable fears, please specify: _____

- Does not recognize danger.
- Runs away frequently.
- Does not observe curfew.
- Problems at mealtimes (disruptive, selective about foods).
- Has problems sleeping
- Frequent lying.
- Sets fires.
- Steals.
- Negative comments to:
 - Parents Siblings Peers Others
- Teasing of:
 - Parents Siblings Peers Others
- Complains frequently.
- Seems frequently sad.

Supplemental Questions:

Has your teen been court involved? No Yes

If "yes," please explain: _____

Do you suspect drug and alcohol abuse? No Yes

Please explain: _____

Please describe other problems: _____

What behavior distresses you the most? _____

What do you think are your child's greatest strengths? _____

How does your teen interact with siblings? _____

