Getting Started Questionnaire

Please answer these questions to the best of your ability with regards to your child. The purpose of this form is to identify a baseline for your child as they begin counseling with me.

1. What brings your child to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you feel comfortable.

2. What are you hoping your child will work on in counseling?

3. Has your child ever seen a therapist or counselor before? ___ Yes ____ No
   If so, when did they last see them?

4. Has your child ever received a mental health diagnosis before? ___ Yes ____ No
   If so, what was it and when were they diagnosed?

5. If your child is taking any kind of medication, please describe what it is, what it is for, and contact information for the prescribing physician. (put N/A if not applicable)

6. Do you believe your child drinks alcohol? ____ Yes ____ No
   If so, what do they drink and how often?

- [ ]
- [ ]

7. Do you believe your child takes any kind of recreational drugs (marijuana, hallucinogenics, depressants, etc.)?
   If so, what do they take and how often?

8. Has your child ever tried to suicide? ____ Yes ____No
   If so, when and what was the method?

9. Has your child ever intentionally hurt other people or animals? ____ Yes ___ No
   If so, please describe.

10. Does anyone else in your family struggle with their mental health? ____ Yes ___No

11. What grade is your child you in and what school do they attend?

12. Please check any of the following you know your child has experienced in the last 6 months.

	Increased appetite		Decreased appetite
	Trouble concentrating		Difficulty sleeping
	Excessive sleeping		Low or no motivation
	Isolation from others		Fatigue/low energy
	Low self-esteem		Depressed mood
	Tearful or crying more often		Anxiety
	Fear		Hopelessness
	Panic		Other:

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13. Please check any of the following that apply to your child's physical health:

	Headache		High blood pressure
	Stomach issues		Hormone related problems
	Head injury		Chest pain
	Chronic pain		Loss of consciousness
	Heart attack		Bone or joint problems
	Seizures		Kidney issues
	Chronic fatigue		Heart problems
	Numbness and Tingling		Shortness of breath
	Diabetes		Hepatitis
	Asthma		Arthritis
	Thyroid issues		HIV/AIDs
	Sexually Transmitted Infection		Cancer
	Other		

14. What else would you like me to know?