capitalcityconsultants@gmail.com http://www.capitalcityconsultantsonline.com

Parent's Clinical Inquiry

Are you the Father or Mother (circle one)

The following information being gathered is all about you, not your child. You will be instructed to discus your child later in the document.

Social History:

Your name: _____ Date: _____

Gender: ___ F _ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

Who referred you?_____

Who is your CPS work? _____ **Phone #?**_____

Who is your Lawyer? _____ **Phone #?**_____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Significant others (brothers, Friends, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___

_____ _____ _____ ____ ____ ____ ____
_____ _____ _____ ____ ____ ____ ____
_____ _____ _____ ____ ____ ____
_____

Marital Status (more than one answer may apply)

Single____ Divorce in process___ Divorced___

Unmarried, living together_____ How long_____ Married_____ How long_____

Widowed____

Total number of marriages____

Assessment of current relationship (if applicable): _ Good __ Fair ___ Poor

Caregiver's description of marital relationship and family structure:

_____
_____
_____
_____

Parental Information

__ Parents legally married _____ Mother remarried Number of times: _____

__ Parents have even been separated ___ Father remarried: Number of times: _____

__ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? ___ Yes __ No If Yes, please describe: _____

Has there been history of child abuse? __ Yes ___ No

If Yes, which type(s)? __ Sexual ____ Physical ____Verbal

If Yes, the abuse was as a: __ Victim _____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition

Comments on childhood:_____ _____

_____
_____
_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

__ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn __Submissive

____ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ___ Yes __ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? __ Yes ___No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? __ Yes __ No

If Yes, describe: _____

Other cultural/ethnic information: _____

_____

Spiritual/Religious

How important to you are spiritual matters? __ Not __ Little __ Moderate ___Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? __ Yes __ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling?

__Yes __ No If Yes, describe: _____

Current Legal Status

Are you involved in any active cases (traffic, civil, criminal)? __ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? _ Yes ____ No

If Yes, please describe: _____

Past History

Traffic violations: ____ Yes __ No DWI, DUI, etc.: ___ Yes __ No

Criminal involvement: __ Yes ____ No Civil involvement: _ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges Date Where (city) Results

Education

Fill in all that apply: Years of education: _____

Currently enrolled in school? ___ Yes ____ No

__ High school grad ____GED

__ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

__ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

__ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

_____

Behaviors at School:_____

_____

_____

Employment

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____

Currently: __ FT _ PT ___ Temp ____ Laid-off ___ Disabled ___ Retired

__ Social Security _ Student ____ Other (describe): _____

Military

Military experience? ___ Yes __ No Combat experience? ___ Yes ___ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Support System

Please comment on your support system, who they are and how they are of help

_____

_____

Who are your closest friends? What do they do? Do they have involvement with the law?

_____

_____

_____

_____

Has a close friend or a member of your family died in the past 2 years? Y N Explain:
_____
_____
_____

Medical/Physical Health

____ AIDS	___ Dizziness	____ Nose bleeds
____ Alcoholism	___ Drug abuse	____ Pneumonia
____ Abdominal pain	___ Epilepsy	____ Rheumatic Fever
__ Abortion	___ Ear infections	__ Sexually transmitted diseases
____ Allergies	___ Eating problems	____ Sleeping disorders
__ Anemia	___ Fainting	____ Sore throat
____ Appendicitis	___ Fatigue	____ Scarlet Fever
__ Arthritis	___ Frequent urination	____ Sinusitis
____ Asthma	___ Headaches	____ Small Pox
____ Bronchitis	___ Hearing problems	____ Stroke
____ Bed wetting	___ Hepatitis	____ Sexual problems
____ Cancer	___ High blood pressure	____ Tonsillitis
____ Chest pain	___ Kidney problems	____ Tuberculosis
____ Chronic pain	___ Measles	____ Toothache
____ Colds/Coughs	___ Mononucleosis	____ Thyroid problems
____ Constipation	___ Mumps	____ Vision problems
____ Chicken Pox	___ Menstrual pain	____ Vomiting
____ Dental problems	___ Miscarriages	____ Whooping cough
____ Diabetes	___ Neurological disorders	____ Other (describe): _____
____ Diarrhea	___ Nausea	_____

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	_____	___ No __ Low ___ Med ___ High
Lunch	____ / week	_____	___ No __ Low ___ Med ___ High
Dinner	____ / week	_____	___ No __ Low ___ Med ___ High
Snacks	____ / week	_____	___ No __ Low ___ Med ___ High

Comments: _____

_____

Current medications and Over the Count medications

Medication	Dose	Start Date	Purpose	Side effects

Are you allergic to any medications or drugs? ____ Yes __ No

If Yes, describe: _____

_____

Procedure	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
most recent surgery			
Other surgery			

Family history of medical problems: _____

Pleases check if there have been any recent changes in the following:

__ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

__ Physical activity level ____ General disposition ____ Weight ____Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Substance Use History

Substance	Typical Amount used	How Often	Age 1st Used	Last Time Used
Misuse of Perscription Medications				

Cocaine/Crack				
Heroin/Opiate				
Marijuna				
Alcohol				
LSD/Mescaline/PCP Ecstasy/Mushrooms				
Inhalants/Huffing				
Other Drugs_____				

Drug or Substance of Choice?

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically uses substances:

_____

_____

_____

Describe any changes in your use patterns: _____

_____

Reason(s) for use:

__ Addicted ___ Build confidence ___ Escape ___ Self-medication

__ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Have you ever been urged to cut down or stop by family and friends? Yes___ No___

Have you felt annoyed or angry when someone comments on your drinking or substance use? Yes___ No___

Have you felt guilty or regretted some of the things you've done while drinking or using substances? Yes___ No___

Have you ever had a drink or used substances to get you going in the morning or steady your nerves? Yes___ No___

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?___ Yes ___ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?

__ Yes __ No If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_____

_____

Does your body temperature change when you drink? . Yes ____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ___ Yes No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

Service	When	Where	Experience
Counseling or Therapy			
Drug and Alcohol Treatment			
Psychiatric Medication Management			
AA, NA, other 12-step groups			
Other Self Help Groups			
Psychiatric Hospitalization			

Have you ever attempted suicide? ____Yes ____No Explain_____
Have you ever felt suicidal? ____Yes ____No Explain_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _____
_____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

Emotional Response to having your child(ren) removed?_____

_____

_____

_____

_____

_____

_____

_____

***** Beginning here please discuss all questions with regards to your children that have been removed. Please specify each child in each question so this evaluator can note differences in your knowledge and relationship. This section does not apply to children not removed.**

Your attitude and concerns regarding the removal of your children:

In your own words why were your children removed?

What do you think you could change to avoid the need for removal in the future? How long will this take to change? What will you need assistance with to make this happen?

What has your communication with the children been regarding why you can't live with them? What would you like to tell them?

Are there any individuals you will need to keep your children away from? Is this possible? Why or why not?

Where will you live when the children move back in with you? What, if any, changes will need to be made to the living environment?

Your prior and current relationship with the children and responsibility for care taking:
(Please describe all of the following… use additional paper if needed).

Reaction to pregnancy and childbirth, and impact of these on the relationship and
Functioning outside of the family

Early caretaking

Current caretaking

Punishment/ Discipline Style

Leisure activities

Interactional style

Past allegations of abuse Neglect

Your prior, current, and anticipated living and working arrangements:
(Please describe all of the following… use additional paper if needed).

Significant others

Daycare, Babysitting

Schools and School Districts

How is each of your children performing in school?

Your Work

a. Hours
b. How long you've been employed
c. Type of work

Additional Questions:

Are you willing to engage in treatment to ensure safety for your children?

Are you willing to allow others to work with you in your home?

Are there areas you are not willing to address?

Identify each child's interests, fears, skills, and problem areas:
How would you solve each?

What is your greatest strength as a parent?

What is your greatest weakness as a parent?

What is the other parents greatest strengths and weaknesses (if applicable)?

Who do you seek advice from when you are having parenting struggles?

What are your current childcare arrangements?

a. Do you believe they will change and how so?

Who else would be living with you?

For each of your children, specify when he or she learned to walk and talk, when the child was toilet trained, any unusual childhood illnesses, and any eating or sleeping problems?

Identify the special needs of each of your children at this time:

Do you believe you have the necessary skills to work with these special needs? Explain why or why not? Do you need help? What accommodations will you need to help you be successful?

What are the specific needs that each of your children will have next year?
In 3 years?

In 5 years?

Who provided your child or children with sex education (if applicable per child's age):

Who taught your child or children about oral hygiene?

Who taught your child or children about general hygiene?

How, do you feel, will the removal of your child affect your child or children?

What has each of your children been told about the living arrangements?

What do you think are the wishes of your child or children regarding custody placement?

What is the bedtime routine of your child or children?

List the ages and sexes of the friends and relatives with whom your child or children come into regular contact:

How often do you allow your child or children to have friends in the home?

All children misbehave from time to time. For each of your children, list a misbehavior and how you handled it:

How often do you find that you have to spank your child or children?

List the name of each child's teacher and each child's grade level, favorite subject, and most difficult subject:

Over the past year, what school events have you attended?
When were they held?

How often does each child need help with his or her homework?

How does each child know you love him or her?

How often do you visit with each child? When are the visits and where?

In the past month, how often have you been angry with the other parent?
What is the typical source of anger?

Are there any current financial or other stressors that might impact your child or children and the household? If so, how might these be resolved?