Family Therapy Center of Northern Virginia, llc

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Child and Adolescent Questionnaire

Child/teen's name _____Age:_____ Grade _____

School: _____

DOB: _____ Who has legal custody? _____

Parent's name: Mo:_____

Home: _____ Is it ok to leave a message here? **Y/N**

Cel: _____ Ok to leave a message? **Y/N** Do you text? **Y/N**

Place/position of employment _____

Home address _____

Parent's name: Fa:_____

Home # _____ Is it ok to leave a message here? **Y/N**

Cel: _____ Ok to leave a message? **Y/N** Do you text? **Y/N**

Place/position of employment _____

Home address _____

Sometimes progress from appointments is relayed in an email to parents. Do you offer consent for progress emails if necessary? **Y/N**

A good e-mail address for contact: Mom _____

A good e-mail address for contact: Dad _____

Do you want auto reminders of appointments? **Y/N** If yes, by email or text? (Circle one)
If text, who is the cell carrier? _____

Please answer the following questions honestly yet briefly. Together we will discuss the questions in greater length for clarity and relevant details.

Please describe what you anticipate services will help improve:

_____

_____

When did the symptoms begin? _____

Why did you choose to begin therapy *now*? _____

_____

Any significant changes or losses in the past 18 months?

_____

_____

Is there anything from birth to present that I may need to know (ie, meds/hormones during pregnancy…prenatal, neurological, developmental or medical issues)?

_____

_____

List any medications your child/adolescent is currently taking & why:

_____

List any specialists, psychiatrists, therapists or other professionals who are or have been involved:

_____

_____

Who referred you? _____ May I thank them? Y/N