WHOLE JOURNEY

Parent Evaluation of Child/Teen/Family

Please note that although this is a self-assessment, issues reported may be utilized to formulate a diagnosis and treatment plan. You can change your answers at any time. Feel free to speak to your clinician regarding any questions or concerns.

Name of Child/Teen:_____ Date:_____

Name of Person Completing the Form: _____ Relationship to Child:_____

Current Concerns (What are the main reasons you are seeking help?)

	Primary Issue	Important Issue
Personal/Emotional Issues		
Family Relationships		
School Problems/Grades		
Parent/ Marital Issues		
Child/Parenting Concerns		
Behavioral Problems		
Health Problems		
Other Life Stressors		

How long have these problems been going on?_____

What have you done to address these problems?_____

_____

_____

What do you think is causing these problems?_____

_____

_____

Have you or your family experienced any major life changes in the past few months?

_____

Who lives in your household?

Name	Age	Relationship to You

Siblings

Name	Age	Biological, step-sibling, half-sibling or adopted

Client's parents' marital status? (Choose all that apply)
Together/Married Age_____
Divorced/Separated Age_____
Deceased Age_____
Dating Age_____
Remarried Age_____
Raised by caregiver guardian other than parents If so: who_____

Significant life trauma(s)/losses:

Trauma/Loss	When

Any history of suicidality/homicidality?

Suicide Attempt(s)	Yes	No	How/When?
Current/Recent Suicidal Thoughts	Yes	No	Last time? Plan:
Homicidal/Violent Thoughts	Yes	No	Last time? Describe:

Additional
Comments:_____

_____

Child/Teen Substance Use History

Alcohol Use	Choose One			
Frequency of Use	None	Monthly	Weekly	Daily
How Much?	None	1-2	3-5	More than 5
Drink of Choice	Beer	Wine	Hard Liquor	
Do you think it's a problem?	Yes	No	Unsure	

Other Drug Use Check box below

	Frequency of Use			
Marijuana	None	Occasionally	Weekly	Daily
Other non-prescriptive drug	None	Occasionally	Weekly	Daily

Prescription drugs used not as prescribed	None	Occasionally	Weekly	Daily

If yes, list what substances_____

If yes, what prescriptions_____

Child/Teen Treatment History

List hospitalizations for medical, psychiatric or chemical dependency problems.

Date	Reason (s)	Hospital

Previous or current therapy; counseling:

EAP or substance abuse treatment: Individual therapy
Marital/couples therapy Group therapy
12-step program Medication management/psychiatrist
Pastoral/Religious Provider

Provider/Type of Counseling/Therapy	When	Reason sought treatment

Parent/Family Problem History:

Is there a family history of any of these issues? (circle all that apply)
Substance Abuse (Y/N) Mental Illness (Y/N) Suicide (Y/N)

Name	Relationship to You	Issue

Symptom Checklist:

Check all that apply to how you have been feeling

	Sleep problems		Memory problems		Hard time sitting still/restless
	Not enjoying things		Loss of time		Worrying a lot
	Problems at work		Racing heart beat		Drug/alcohol use
	Obsessive thoughts		Nervous or tense/unable to relax		Concerns about sexual feelings or identity
	Lack of friends		Relationship problems		Other sexual concerns
	Stomach aches/digestive problems		Shy/uncomfortable around others		Not feeling confident
	Feeling panic and fear		Problems concentrating		Racing thoughts
	Feeling anxious		Grief or loss		Problem eating habits
	Not feeling good enough		Feeling hopeless		Feeling worthless
	Compulsive behaviors		Disturbing thoughts		Not getting along with others
	Wanting to hurt self		Mood swings		Shaking/trembling
	Wanting to harm others		Feelings of wanting to die		Chronic pain

	Aggressive/abusive		Sadness or depression		Childhood issues
	Angry easily or a lot		Confused thinking		Problem staying on task
	Problems with sexual thoughts/behavior		Problems with decision making/judgment		Concerns about family members
	Irritable		Abused by others		Illegal behavior
	Isolating/not wanting to be around others		Impulsive/Doing things without thinking		See or hear things others don't
	Self harm behaviors		Disorganized thoughts		Weight concerns
	Concerns about gender		Feeling helpless		Other addictive behaviors

Parent's Work History

Current Employment Status Check box below

Employed, full-time	
Employed, part-time	
Student	
Self-employed	
Homemaker/stay at home parent	
Retired	
Other Specify:	

Check box below related to employment

Job Satisfaction	Very Satisfied	Moderately Satisfied	Not Satisfied at all

Family & Extended Family Relationships:

Did you (parent) experience any of the following as a child/young adult?

School problems	Yes	No	Age:
Depression	Yes	No	Age:
Substance Abuse	Yes	No	Age:
Legal problems	Yes	No	Age:
Sexual/physical abuse	Yes	No	Age:
Domestic violence	Yes	No	Age:

Did you experience any other major childhood issues? Yes or No

If yes, describe:_____

_____

Family Treatment History

List hospitalizations for medical, psychiatric or chemical dependency problems.

Who	Date	Reason

Previous or current therapy; counseling:

EAP or substance abuse treatment: Individual therapy
Marital/couples therapy Group therapy
12-step program Medication management/psychiatrist

Pastoral/Religious Provider

Provider/Type of Counseling/Therapy	When	Reason sought treatment

Cultural and/ or ethnic observations or considerations:_____

Spiritual and/or religious considerations:_____

Please write down any other information that would be helpful for me to know about the problems, situation, (including family/school, etc situations that might be contributing to child's/teen's problems and are possible obstacles to making things better).

_____

_____

_____

What you would like for your child/family to accomplish in treatment? What goals do you have?

_____

_____

_____

_____

_____

_____ _____

Signature* Date