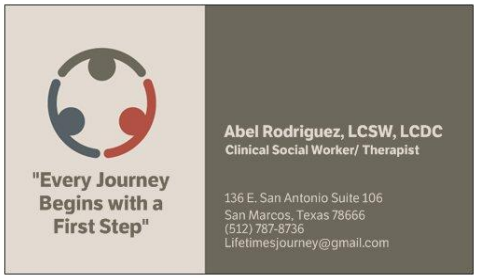


Parental Assessment Profile

Due to the fact that your child is a minor, this assessment should be the parent's view of their child. Please complete the following information to the best of your ability and recollection.

PERSONAL INFORMATION:

Name of Patient:_____

Date of Birth:_____ **Age:** _____

Please list any person living in the child's home:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list other immediate family members not currently living in the child's home:

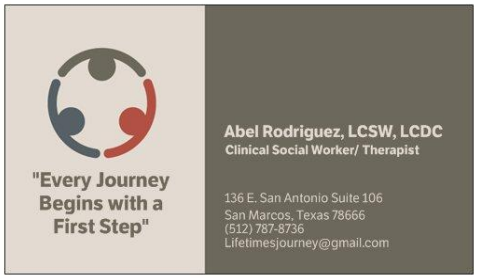
Name	Age	Relationship	Quality of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mother's occupation:_____ **Father's occupation:**_____
Approximate family income: _____ **Family's religion:**_____

If the child was adopted, at what age? _____
Does the child know he/she was adopted? _____
Age when told about the adoption? _____
Has the child had any contact with the biological parents since the adoption? ___
Does the child mention the biological parents?_____

EDUCATIONAL INFORMATION:

School: _____ **Grade:** _____
Does the child seem to like his or her teacher? _____
What is the child's behavior at school?_____
Has the child ever failed a grade or been held back?_____
If so, please explain:_____



Has the child ever received special education, special resource, or speech services? _____ Explain: _____

MEDICAL INFORMATION:

Physician: _____ Date of last physical exam: _____

Please list any illnesses or medical conditions:_____

_____

_____

List any medication to which the child is allergic: _____

_____

Please list any medications the child takes:

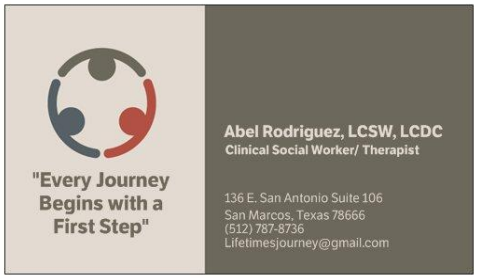
Medication	Amount of Dose	Frequency	Purpose of Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check and explain any concerns or events from the list below:

___The child's weight or diet: _____
___Has the child ever been unconscious from a head injury? _____
___Has the child ever been neglected, traumatized, or abused? _____
___Has the child had previous counseling or testing? _____
___Has the child ever been hospitalized? _____
___Has the child tried or used drugs, tobacco, or alcohol? _____
___Does the child drink caffeine (soda, tea, coffee) and how much? _____

Has any person in the child's biological family ever:

___Had depression? **___Had a problem with alcohol or drug abuse?**
___Had schizophrenia? **___Had bipolar or manic-depressive disorder?**
___Committed suicide? **___Been imprisoned for a felony?**
___Had an anxiety disorder? **___Had a learning disability or ADHD?**
___Been hospitalized for a psychiatric illness?
___Has the child ever been the victim of a crime?
If so, please explain: _____



SOCIAL/RECREATIONAL INFORMATION:

Please list the child's hobbies and interests:
How well does the child get along with peers? _____
Does the child have a best friend? _____
Does the child have a TV in the bedroom? _____
Estimate the # of hours per week the child watches TV: _____
Estimate the # of hours per week the child plays video/computer games: _____
Does the child have access to the internet? _____
Do you restrict access to the internet, games and/or movies with violent or sexual content? _____

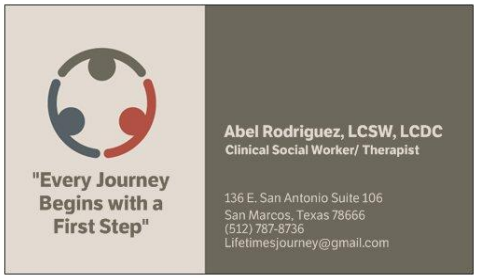
PRESENTING PROBLEM:

Please explain why you are seeking treatment for your child:_____
_____
_____
_____
_____

How severe are these concerns to you? Mild Severe Extremely severe
How severe are these concerns to the child: Mild Severe Extremely severe
When did the problem(s) begin? _____
What have you done to try and solve the problems? _____
_____
_____

Please check any symptoms your child is having:

___Tiredness
___Difficulty
___sleeping
___Increased tears
___Argues a lot
___ Loss of interest in activities
___Nervousness
___Irritability
___Withdrawal from others
___Clinging
___Worries a lot
___Changed eating habits
___Destructive
___Refuses to go to school
___ Hurts self or talks about it
___Poor attention
___Aggressive behavior
___ Hurts others or talks about it
___Nightmares
___Soils or wets self
___ Grades have dropped
___ Over sleeps
___Rude to parents
___ Won't follow instructions
___Disobedient
___Strange ideas:_____
Other: _____



Please check any recent changes the child has experience:

___Illness or injury
___Moved
___Friend moved
___Sibling left home
___New family member
___Parent left home
___Loved one died
___Experienced or witnessed
___Violence Parents divorced
___Child moved into/away from family
___ Other major loss or event:
___Other: _____

I give permission to *Abel Rodriguez, ,LCSW, LCDC* to treat my child _____in psychotherapy. I am the custodial parent or legal guardian of the child and I have the legal authority to authorize treatment.

___Without the consent of anyone else.
___Only with the consent of

_____
Name

_____
Address (number and street)

_____
City, State, and Zip Code

_____
Phone Number

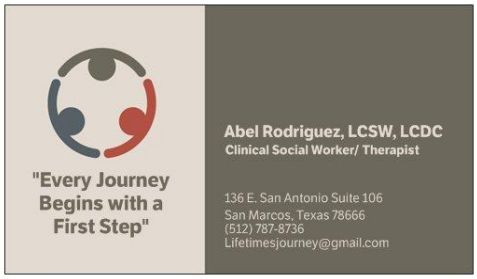
___I agree to provide any necessary documentation (Upon request).

I understand that no child custody evaluation will be performed and that therefore my therapist will not formulate an opinion regarding any custody issues, and that requiring the therapist to testify regarding custody issues would be harmful to my child and the therapeutic relationship.

_____
Printed Name of Parent/Guardian

_____
Relationship to Child

_____ _____
Signature Date



Thank you for selecting me as your child's therapist. Please feel free to discuss any concerns you may have about your child's treatment. At any time that I am alone with your child, you are invited to open the door and check on your child's well-being. The ending of therapy is as important to children as what takes place within it and I request that you talk with me about how therapy will terminate before we actually end.

_____ _____

Signature **Date**