Recovery Pathways, LLC

Parent Questionnaire

To be filled out by the parent or guardian: If you need help with reading and/or writing, please take this form to the front desk and they will arrange for someone to help you.

It is very important to the outcome of your family's treatment experience that the therapist understands as much about your child and family as possible. Please answer the following questions as honestly as you can. Feel free to add any other information you would like to include. If a question does not apply to you, your child, or your situation, please write "N/A". If you do not know the answer, write "unknown". Your therapist will review this questionnaire, and may ask for additional information. All information is confidential.

1. Child's full name:_____
2. Nickname(s): _____
3. Person completing this form (Name/Relationship to the child): _____
4. Parents are currently:____Married ____Divorced ____Separated ____Never Married ____Deceased
5. List all people living in the child's home(s): _____

   _____
6. How would you describe your child's cultural/ethnic/spiritual background? _____

   _____
7. In your own words, why are you seeking treatment for your child? _____

   _____

   _____

   _____
8. Has your child had problems with any of the following areas?

   ___School (academics, attendance, behavior, etc.) ___Legal ___Temper problems ___Shyness
   ___Pregnancy (self or girlfriend) ___Abortion (self or girlfriend) ___Lying ___Depression
   ___Anxiety ___Behavior Problems ___Gang Involvement ___Physical Abuse
   ___Sexual Abuse ___Emotional Abuse ___Suicide Attempts ___Running Away
   ___Others (Please describe)_____
9. Do you believe that your child could be using alcohol/drugs? ___Yes ___No
10. Are you willing to participate in family sessions with your child? ___Yes ___No
11. How would you rate the communication between you and your child?

    ___Excellent ___Good ___Fair ___Poor
12. What do you see as the strengths of your family? 1._____

    2._____ 3._____

Ortonville Location
380 Mill Street
Ortonville, MI 48462
Phone 248-961-3088
Fax 248-627-7685

Essexville Location
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Essexville, MI 48732
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Fax 989-391-9596

13. What do you see as strengths/abilities of your child? 1._____

    2._____ 3._____

14. Please comment on how your child uses his/her free time: _____

    _____

15. Please comment on how your child relates with his/her peers: _____

    _____

16. Please comment on how your child relates with other adults/authority figures: _____

    _____

17. Has your child ever been kicked out of the family home? _____Yes _____No
18. Has your child ever been removed from the family home? _____Yes _____No
19. Has your child ever been diagnosed with a learning disability? _____Yes _____No
20. Do you believe that your child under-reacts or over-reacts? _____Yes _____No
21. Is there, or has there ever been, anyone in your child's life who has shown problems with alcohol/drugs?

    _____Yes _____No

22. How does your child relate with his/her siblings? _____

    _____

23. How has your child's behavior impacted the family? _____

    _____

24. What changes do you hope to see as a result of treatment? _____

    _____

25. Is there any other information you feel is important? _____

    _____

    _____

    _____

    _____

_____ _____

Patient/Guardian Signature Date

_____ _____

Therapist Signature Date

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