

Atlanta Center For Eating Disorders Confidential Parent Questionnaire

Information requested on this questionnaire will be helpful in the diagnostic process. Please feel free to add as much information as you want on the back of these pages. This information is strictly confidential.

Name of person completing form/relationship to child _____
Date _____

Background Information

Child's Name _____ Birthdate _____ Age _____ Sex _____
School _____ Grade _____

Describe the reasons you are requesting this treatment for your child. If possible, list specific questions for which answers are sought.

Pregnancy and Birth History

Was the pregnancy with this child a planned pregnancy? _____

Where was your child born? _____

Length of pregnancy: _____ Mother's age when child was born: _____

Prenatal exposure to drugs, alcohol, nicotine, other (eg. falls, traumas)? Yes _____ No _____ If yes, please describe:

Describe any complications that occurred during pregnancy (excessive vomiting, toxemia, medications, alcohol or drug consumption, infections, etc.).

Describe any complications that occurred during delivery (prematurity, postmaturity, length of labor, special procedures, etc.).

Birth weight _____ Apgar score _____ Length of labor _____

Were there any complications after delivery (jaundice, weak sucking instinct, birth defects, respiratory problems, vomiting, infection, etc.)?

Early Temperament

Describe the child's temperament during the first six months (i.e., sleep patterns, colic, eating patterns, did not enjoy cuddling, "easy baby," etc.).

Did your child experience any developmental delays (rolling over, sitting up, language development, etc.)? Explain. _____

Is your child under the care of any specialist? For what? Are any future medical procedures planned? _____

Have there been any previous psychological, psychiatric, or neurological evaluations? If so, please list names, addresses, and dates of contact. Please attach any pertinent reports. _____

Social/Emotional/Behavioral History

List your child's personality characteristics, both positive and negative. _____

Note any particular behavior concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, attending difficulties, destructiveness, picking at hair or skin, unusual habits, fears, bizarre ideas, sex related issues, tenseness, etc.). _____

Current discipline techniques: _____

Who disciplines? _____

Has your child been in treatment for any mental health issue in the past? Please describe. _____

Has your child experienced any academic difficulties? Please describe. _____

Family Information

Mother's name _____ Home phone _____

Address _____ Cell phone _____

Occupation _____ Work phone _____

Any history of emotional/mental problems? If so, please explain: _____

Any history of substance use/abuse/dependence? If so, please explain: _____

Any previous marriages? Children from previous marriages? _____

Father's name _____ Home phone _____
Address _____ Cell phone _____

Occupation _____ Work phone _____

Any history of emotional/mental problems? If so, please explain: _____

Any history of substance use/abuse/dependence? If so, please explain: _____

Any previous marriages? Children from previous marriages? _____

Marital status: Mother: Single _____ Married _____ Divorced _____ Remarried _____ Widowed _____
Father: Single _____ Married _____ Divorced _____ Remarried _____ Widowed _____

Please list the other children in the family and any emotional or physical problems.

Does anyone other than the parents and children live at home? Who?

What activities are you involved in as a family. What things do you enjoy doing together?

What activities are you involved in after school and in the evenings (and on which days?). _____

If your child is admitted to our program and is under 18, it is mandatory that all parents be involved with the treatment. Are you willing to be involved in family therapy once a week? Yes _____ No _____.

What of the above activities could you give up if necessary to be involved in your child's recovery?

Parents often need individual or couples' therapy as well. Are you willing to do this if recommended?
Individual? _____ Couples? _____

We very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments below.

