Elizabeth A. O'Brien, LPC, LLC
132 East Putnam Avenue, 2 East
Cos Cob, Connecticut 06807
914.393.1202

# Registration Questionnaire

**Date** _____
**Name of Child** _____ **Sex** _____ **Date of Birth** _____
**School** _____ **Grade** _____
**Name of Parent/Legal Guardian** _____
**Address** _____
**City** _____ **State** _____ **Zip** _____
**Home Phone** _____**Cell Phone** _____
**Work Phone/Employer** _____
**Email** _____
**Referred by** _____
**Child's Pediatrician/Phone** _____

## Child's Family

List all children/significant others in the family. *(If more room is needed, please use back of this page.)*

| Name | Age | Relation | Living in or outside the home |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Child's parents: Married ___ Separated _____ Divorced _____Widowed _____
If separated/divorced, what is the visitation arrangement? _____
_____
Are there any problems with custody/visitation? Please explain _____
_____
_____

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How does mother discipline child? _____

_____

How does father discipline child? _____

_____

Do parents agree about child discipline? Please explain _____

_____

Please check if any of the following stresses apply to your family:

| | **Yes** | **No** |
|---|---|---|
| Unemployment | _____ | _____ |
| Recent decrease in income | _____ | _____ |
| Illness in family member | _____ | _____ |
| Death in family | _____ | _____ |
| Any other significant losses | _____ | _____ |
| Drug/alcohol abuse in family | _____ | _____ |
| Exposure to violence | _____ | _____ |

# Developmental History

Was your child an easy baby? (i.e. responsive, happy, on a schedule, or was child irritable, fussy, hard to satisfy)

Very easy _____
Easy _____
Average _____
Difficult _____
Very difficult _____

How did your baby behave with other people?

More sociable than average _____
Average sociability _____
More unsociable than average_____

When he/she wanted something, how insistent was he/she?

Very insistent _____
Pretty insistent _____
Average _____
Not very insistent _____
Not at all insistent _____

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How would you rate the activity level of your child as an infant/toddler?

Very active _____
Active _____
Average _____
Less active _____
Not at all active _____

Did your child eat well during the first year? Yes _____ No _____
Did your child gain weight normally during the first year? Yes _____ No _____
Did your child sleep well during the first year? Yes _____ No _____
Please indicate the age at which your child began:
Walking alone _____ Using meaningful words _____

Does your child experience difficulty in expressing his/her thoughts? If so, please describe _____

Did your child have trouble separating from you to start school? Please explain _____

Please list the schools, including daycare, that your child has attended _____

How many times have you moved since your child was born? _____

How does your child interact with?
Mother _____
Father _____
Brothers and sisters _____
Other children _____
Other adults _____

What are your child's favorite activities? (play, toys, sports, hobbies, etc.)_____

What are bedtimes like now? _____

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Does your child display behavior that is particularly stressful for you to handle? If so, please describe _____

_____

_____

Do you suspect that your child is using alcohol or other drugs? If so, please describe _____

_____

_____

Has your child broken any laws? _____
Is your child cruel to animals? _____
Has your child frequently been absent from school? _____
How much time does your child spend watching TV (including video games) each day? _____
Has your child been involved with DCF or the police? If so, please describe _____

_____

_____

_____

## Child's Medical History

General health of your child: Good ____ Fair _____ Poor _____ Date of last physical _____

Has your child ever had surgery for any of the following conditions?

| | **Yes** | **No** |
|---|---|---|
| Tonsillitis | _____ | _____ |
| Adenoids | _____ | _____ |
| Hernia | _____ | _____ |
| Appendicitis | _____ | _____ |
| Eye, ear, nose, throat | _____ | _____ |
| Digestive disorder | _____ | _____ |
| Urinary tract | _____ | _____ |
| Leg or arm | _____ | _____ |
| Burns | _____ | _____ |
| Other | _____ | _____ |

Please describe: _____

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Has your child ever had any accidents resulting in the following?

| | Yes | No |
|---|---|---|
| Broken bones | | |
| Severe lacerations | | |
| Head injury | | |
| Severe bruises | | |
| Stomach pumped | | |
| Eye injury | | |
| Lost teeth | | |
| Sutures | | |
| Other | | |

Please describe any significant medical conditions, illnesses, accidents or operations your child has experienced: _____

_____

_____

Is your child currently taking medications prescribed by a physician? If so, indicate type, amount, length of time taking the medication and any known side effects: _____

_____

_____

If your child is taking medication, do you feel it is helping? _____

_____

Has your child had prior counseling or psychiatric treatment? If yes, please specify therapist's name, phone contact, dates of treatment and initial reason for seeking treatment: _____

_____

_____

Please check the following as applies to your child:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Frequent colds | | | Head injury | | |
| Ear infections | | | Allergies (specify) | | |
| Hearing problems | | | Lacks energy | | |
| Speech problems | | | Asthma | | |
| Language problems | | | Frequent headaches | | |
| Visual problems | | | Eating problems | | |

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| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Sleeping problems | _____ | _____ | Tics/twitches | _____ | _____ |
| Physical complaints | _____ | _____ | Seizures | _____ | _____ |
| Sexual abuse | _____ | _____ | Physical abuse | _____ | _____ |
| Lead poisoning | _____ | _____ | Frequently worried | _____ | _____ |
| Menstrual problems | _____ | _____ | Learning problems | _____ | _____ |

## Reason for Referral

What prompted you to seek assistance at this time? (Be as specific as possible) _____
_____
_____
_____

Who in your family appears most and least stressed by your child's behavior? Please describe:
_____
_____
_____
_____

How do you feel I can best help you? _____
_____
_____