T. Michael Knack, Ph.D.
Licensed Psychologist

_____*Child*

4901 Towne Centre, Ste 205.
Saginaw, MI 48604
(989) 921-5715 Phone
(989) 921-5960 Fax

Parent Report:

You cooperation in completing this questionnaire will be helpful in planning our services for your child. Please answer each item carefully or ask for clarification if you do not understand an item.

Child's Name:_____ Date of Birth:_____Age_____

School:_____Grade: _____

Briefly describe your reason for seeking help: _____

_____

_____

_____

Name of physician: _____

When was your child last examined by a physician? _____

List any major health problems for which your child is currently receive treatment: _____

_____

_____

List all medications your child is currently taking:_____

_____

_____

Has your child ever received a psychiatric or psychological help or counseling of any kind prior to this? _____ If yes, please explain:_____

_____

_____

_____

Please circle any of the following problems which pertain to your child:

Nervousness	Depression	Fears
Shyness	Sexual Issues	Suicidal Thoughts
Separation Problems	Divorce of Parents	Drug Use
Alcohol Use	Making Friends	Anger
Self-Control	Unhappiness	Sleep Problems
Stress	Headaches	Lack of Energy
School Problems –Academic	School Problems-Behavior	Defiant Attitude
Short Attention Span	Impulsivity	Memory Problems
Poor Choice of Friends	Loneliness	Inferiority Feelings
Withdrawal	Cigarette Use	Career Choices
Health Problems	Temper	Nightmares
Stealing or Lying	Overeating	Loss of Appetite
Stomach Trouble	Bowel Troubles	Strange Behavior
Strange Thoughts	Others:	

List members of your family and all others in your home:

Name: Age/Birthdate: Relationship: Occupation:

_____

_____

_____

Please add any information which you feel may be useful to us: _____

_____

_____

_____ _____

Signature of Parent/Guardian Date