

**CHILD INFORMATION QUESTIONNAIRE**  
(To be completed by each parent for child)



Child's Name: \_\_\_\_\_ Sex: Male / Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_

Person completing this form: (name) \_\_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_

Currently this child lives with: (check one)

\_\_\_\_ My spouse and I are in the same household (pre-separation)

\_\_\_\_ Me \_\_\_\_ day(s) per (check one) \_\_\_\_ week \_\_\_\_ month

\_\_\_\_ Other parent \_\_\_\_ day(s) per (check one) \_\_\_\_ week \_\_\_\_ month

\_\_\_\_ Other arrangement (explain) \_\_\_\_\_  
\_\_\_\_\_

**School, Friendships, Social Life**

School or preschool your child attends: \_\_\_\_\_

Name of your child's teacher: \_\_\_\_\_

How many different schools has your child attended? \_\_\_\_\_

Child's academic performance in the past 12 months has been:

\_\_\_\_ Outstanding \_\_\_\_ Above Average \_\_\_\_ Average \_\_\_\_ Below Average

Has there been a change in your child's academic performance over the past 12 months?

(circle one) Yes / No      Comments: \_\_\_\_\_  
\_\_\_\_\_

How does your child feel about school?

\_\_\_\_ Appears to love school \_\_\_\_ Likes it enough \_\_\_\_ Doesn't like school

Does your child participate in extracurricular activities? Describe: \_\_\_\_\_  
\_\_\_\_\_

Approximately how many friends does your child have?

\_\_\_\_ None \_\_\_\_ One or two \_\_\_\_ 2 - 4 \_\_\_\_ 5 - 7 \_\_\_\_ More than 7

Does your child have a best friend? \_\_\_\_ Yes \_\_\_\_ No

Please indicate, with regard to your child, what one personal activity, event, skill, or accomplishment of which you are proudest? \_\_\_\_\_  
\_\_\_\_\_

**Child's Temperament and Coping Skills**

Over the past year, has your child experienced the death of a loved one (i.e. relative, caregiver, friend, pet, etc.), through death, extended separation, moving away, or other circumstances?

Explain: \_\_\_\_\_  
\_\_\_\_\_

How does your child deal with changes (i.e. new schools, babysitters, friends, new schedules, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

What have you found helps him/her cope with these changes? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How does your child deal with separating from you (i.e. leaving for school, sleepovers, camps, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

What helps your child deal with separations? \_\_\_\_\_

\_\_\_\_\_

**Siblings, Relatives, and Family Friends**

Does your child have sisters or brothers? \_\_\_\_ Yes \_\_\_\_ No

What are your concerns about this child's relationships with his/her siblings?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who are other relatives and family friends who are especially important to your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What should we know about his/her relationships with siblings, extended family members, or special family friends?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Check any problems your child has experienced (and add specific information, if desired):**

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Temper tantrums   | <input type="checkbox"/> Restlessness, difficulty sitting still, hyperactive                             |                                      |
| <input type="checkbox"/> Rejection or made fun of by peers                           | <input type="checkbox"/> Complains of loneliness   |                                      |
| <input type="checkbox"/> Bullied or manipulated by peers                             | <input type="checkbox"/> Appears sad, unhappy, or depressed  |                                      |
| <input type="checkbox"/> Shyness   | <input type="checkbox"/> Changes in eating habits  |                                      |
| <input type="checkbox"/> Nightmares  | <input type="checkbox"/> Sleep problems  |                                      |
| <input type="checkbox"/> Bedwetting / soiling at night                               | <input type="checkbox"/> Harms self deliberately   |                                      |
| <input type="checkbox"/> Wetting / soiling during the day                            | <input type="checkbox"/> Suicidal thoughts   |                                      |
| <input type="checkbox"/> Acts young for his/her age                                  | <input type="checkbox"/> Fearful, shy  |                                      |
| <input type="checkbox"/> Difficulty making friends                                   | <input type="checkbox"/> Refuses to go to school   |                                      |
| <input type="checkbox"/> Difficulty keeping friends                                  | <input type="checkbox"/> Clingy with parents, caregivers   |                                      |
| <input type="checkbox"/> Aggressiveness, picking fights                              | <input type="checkbox"/> Destroys property of self, family, others                                       |                                      |
| <input type="checkbox"/> Discipline problems at school                               | <input type="checkbox"/> Accident-prone  |                                      |
| <input type="checkbox"/> Cruel or malicious to other children or animals             | <input type="checkbox"/> Use of non-prescription drugs, abuse of prescription drugs, or abuse of alcohol |                                      |
| <input type="checkbox"/> Delinquent acts such as breaking windows, shoplifting, etc. | <input type="checkbox"/> Noticeable difficulty with changes in routines, schedules                       |                                      |
| <input type="checkbox"/> Argues a lot  |  |                                      |
| <input type="checkbox"/> Difficulty concentrating                                    |  |                                      |
| <input type="checkbox"/> Physical complaints with unknown causes:                    |  |                                      |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Nausea, vomiting  | <input type="checkbox"/> Aches/pains |
| <input type="checkbox"/> Rashes, skin problems                                       | <input type="checkbox"/> Stomach aches   |                                      |

**Child's Perceptions, Reactions to the Separation/Divorce**

What are your child's reactions to the circumstances surrounding your separation/divorce?

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What have you told your child about the situation?

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Does your child ask questions or talk about the separation/divorce? If so, about what does your child seem most concerned?

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In what ways might your child benefit from the separation/divorce?

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**Parent-Child Relationship**

What are your strengths as a parent?

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What would you like to improve as a parent?

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How do you think the child's other parent would describe their strengths?

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What do you think are the other parent's strengths as a parent?

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What do you think the other parent would like to improve in their parenting?

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What, if any, major disagreements have you had with this child's other parent regarding child-rearing and parenting?

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What has been the most enjoyable time for you with this child?

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What do you find most satisfying about parenting this child?

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List three hopes / dreams you have for this child:

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