

General Information

I would appreciate your taking the time to complete this questionnaire. It will help me to determine your child's treatment programs. All of the questions are optional, but please answer as many as you can.

1. Child's Name _____

Preferred Name or nickname _____

Any special pronunciation _____

2. With whom does your child live? _____

3. Mother's Name _____

Address _____

4. Father's Name _____

Address _____

5. Child's Age ____ Birth Date __/__/____

6. Name and Age of siblings:

Brothers _____

Sisters _____

7. How do you rate your child's health? _____

8. What foods does your child like? _____

9. What foods does your child dislike?

10. How many hours of sleep per night does your child need? _____

11. How does your child act when afraid? _____

21243 Ventura Boulevard, #229 - Woodland Hills, California 91364

(818) 207-1191

12. What are your child's strengths? What is he or she good at? _____

13. What are your child's favorite activities? _____

14. How do you believe your child learns best? By watching? By reading? By listening? Some other way? _____

15. What tasks does your child like to do at home? _____

17. What tasks does your child not like to do at home? _____

16. Does your child spend money immediately or save it? _____

17. What are your child's weaknesses? _____

18. What are your child's fears? _____

19. Is there anything your child is trying to accomplish right now that he or she feels is very important? _____

20. In general, how do you think your child feels about him- or herself? _____

21. In general, how do you feel about your child? _____

22. What is your dream for your child? _____

Ella Begelfor, MA,

3

Please add anything additional you would like me to know in order to best help you and your child.

Signature of person completing this form

Date