Pediatric Associates of Alexandria Initial Therapy Questionnaire

Child's Name:
Child's Age:
Grade Level:
Emergency Contact (Name/Relation and Contact Number):

Presenting Issue/Chief Complaint:

____
____
____
____
____

What are {the parents} you seeing at home?

____
____

Are there any issues at school?

____
____

Current Coping Skills:

____
____

Favorite Coping Item (i.e., stuffed animal, aroma):

____

Hobbies/Interests:

____
____

Living situation and inhabitants and/or are there any pets?

____

What are you hoping to gain from therapy?

____
____
____