

CHILD/ADOLESCENT INTAKE/QUESTIONNAIRE

TODAY'S DATE _____

CLIENT NAME:

FIRST: _____ MIDDLE: _____ LAST: _____

MAILING ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ BIRTHDATE _____ AGE _____ SEX M/F

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

EMPLOYMENT STATUS Full-Time Part-Time None Self Employed Active Military

STUDENT STATUS Full-Time Part-Time None

RESPONSIBLE PARTY INFORMATION

(Only IF Different from Client Information Above)

FIRST NAME _____ MIDDLE _____ LAST _____

BILLING ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____

RELATIONSHIP OF CLIENT TO RESPONSIBLE PARTY: Spouse Child Other: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

INSURANCE INFORMATION

(Please Provide Copies of ALL I.D. Cards . FRONT and BACK, If Applicable)

If You Have No Insurance and You Will Be Solely Responsible For Payment check here: ____ (Skip to the next page).

PRIMARY INSURANCE NAME: _____ **PHONE:** _____

EFFECTIVE DATE: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE _____ ZIP _____

SUBSCRIBER'S NAME: _____ SEX M/F DATE OF BIRTH: _____

SUBSCRIBER'S I.D. # _____ GROUP # _____ SUBSCRIBER'S

EMPLOYER _____ DEDUCTIBLE \$ _____ COPAYMENT \$ _____

RELATIONSHIP OF CLIENT TO SUBSCRIBER: Self Spouse Child Other _____

SECONDARY INSURANCE NAME: _____ **PHONE:** _____

EFFECTIVE DATE: _____

CLAIMS ADDRESS: _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER'S NAME _____ SEX M/F DATE OF BIRTH: _____

SUBSCRIBER'S I.D. # _____ GROUP # _____ SUBSCRIBER'S

EMPLOYER _____ DEDUCTIBLE \$ _____ COPAYMENT \$ _____

RELATIONSHIP OF CLIENT TO SUBSCRIBER: Self Spouse Child Other _____

Child/Adolescent Questionnaire to be completed by parent/guardian.

Directions: Please complete this form with reference to the child/teen for whom you are seeking help.

Client's Name: _____ **Age:** _____ **Date of Birth:** _____

Date Today: _____ **Home and Cell Phone:** _____

STREET ADDRESS: _____ **CITY:** _____ **STATE** _____ **ZIP** _____

MARITAL STATUS: **PHONE:**

Parent/Guardian Names:

Mother:

Father:

Stepmother:

Stepfather:

Other:

If parents are divorced/separated, is there a custody order? ___ Yes ___ No
(If so, and only one parent is present for the intake, you will be asked to produce a copy of the custody order prior to any subsequent appointments).

Siblings/Other Household Members:

Name: **Age:** **Relationship to child:**

Languages Spoken at Home: _____

Please describe why you are seeking treatment: _____

When did the problem start? _____

How would you rate the severity of the problem right now?

0 1 2 3 4 5 6 7 8 9 10
Mild severe

Problem Checklist

Please indicate which of the problems below are bothering the child at this time:

0=none 1=mild 2=moderate 3=serious 4=severe

- | | |
|---------------------------------------|---|
| 0 1 2 3 4 Suicidal Thoughts/behaviors | 0 1 2 3 4 Hears Voices |
| 0 1 2 3 4 Self Harm | 0 1 2 3 4 Sees things not there |
| 0 1 2 3 4 Feels Hopeless | 0 1 2 3 4 Fits of rage |
| 0 1 2 3 4 Feels Worthless | 0 1 2 3 4 Overly suspicious |
| 0 1 2 3 4 Irritable | 0 1 2 3 4 Few friends |
| 0 1 2 3 4 Sad/Tearful | 0 1 2 3 4 Excessively shy |
| 0 1 2 3 4 Moody | 0 1 2 3 4 Bossy |
| 0 1 2 3 4 Bully | 0 1 2 3 4 Overly sensitive |
| 0 1 2 3 4 Poor sleep | 0 1 2 3 4 Teases others |
| 0 1 2 3 4 Too much sleep | 0 1 2 3 4 Teased by others |
| 0 1 2 3 4 Nightmares | 0 1 2 3 4 Cruel to others/animals |
| 0 1 2 3 4 Poor concentration | 0 1 2 3 4 Lying |
| 0 1 2 3 4 Excessive worry/fears | 0 1 2 3 4 Stealing |
| 0 1 2 3 4 Panic | 0 1 2 3 4 Fire setting |
| 0 1 2 3 4 Irregular eating habits | 0 1 2 3 4 Runs away |
| 0 1 2 3 4 Weight preoccupation | 0 1 2 3 4 Aggression |
| 0 1 2 3 4 Nail biting | 0 1 2 3 4 Truancy |
| 0 1 2 3 4 Repetitive behaviors | 0 1 2 3 4 Sexual acting out |
| 0 1 2 3 4 Thumb sucking | 0 1 2 3 4 Legal problems |
| 0 1 2 3 4 Soiling in pants | 0 1 2 3 4 Authority conflicts |
| 0 1 2 3 4 Bed wetting | 0 1 2 3 4 Tics |
| 0 1 2 3 4 Attention seeking | 0 1 2 3 4 Accident prone |
| 0 1 2 3 4 Stuttering | 0 1 2 3 4 Excessive physical complaints |

CHILD'S BIRTH AND EARLY DEVELOPMENT:

Was the pregnancy: Planned Yes/No Desired Yes/No

Was the child adopted: Yes/No

Were any of these substances used during pregnancy?

Alcohol Yes/No Caffeine Yes/No

Drugs Yes/No (Please specify if yes)_____

Cigarettes Yes/No

How was mother's health during pregnancy?

Birth Weight _____ **Premature** Yes/No **Post mature** Yes/No

Type of Delivery: _____ Problems at birth: _____

Feeding difficulties: _____

Sleeping difficulties: _____

Breast fed: _____ months Bottle fed: _____ months

As an infant, did the child have regular sleeping and eating habits? _____

Age when child:

Sat alone ____ Walked alone ____ Spoke first words ____ Crawled ____ Toilet trained

____ Bowel trained ____ Spoke first phrases ____ Spoke first sentences ____

Anything unusual about speech development? _____

Describe personality in early childhood _____

Medical History:

Please describe all serious illnesses, accidents and surgeries

Illness/accident/surgery Age Hospital Stay? How Long?

Any other medical concerns? _____

Age at onset of puberty _____

Age at onset of menstruation _____

Irregular or absence of menstrual periods Yes /No

Seizures Yes /No

Any eye problems Yes /No

Any hearing problems Yes /No

Blackout spells Yes/No

Prior psychiatric/psychological treatment, hospitalization or medication: Yes/ No

If yes, where and when? _____

Current medications/doses _____

List all Drug allergies/adverse reactions

DRUG/ALCOHOL HISTORY:

Past or present history of Drug/Alcohol Abuse: Yes/ No

If yes, please describe: _____

Has your child *experimented* with alcohol or drugs? Yes/No/Don't

Know _____

Has your child had any police/legal involvement? Yes/ No

If yes, describe: _____

SCHOOL HISTORY:

Name of School: _____

Teacher: _____

Counselor: _____

Grade: _____

Please circle Yes or No to all responses regarding your child's school experiences:

- No significant problems Yes /No
- Learning disabilities Yes /No
- Academic Achievement problems Yes/ No
- School avoidance/phobia Yes/ No
- Truancy Yes/ No
- Behavior Problems Yes/ No
- Peer problems Yes/ No
- IEP Yes /No
- 504 Plan Yes/ No

Has your child been achieving about as well as you feel he or she should? Yes /No

What best describes the grades s/he usually gets?

- ___ Well Above Average
- ___ Somewhat Above Average
- ___ Average
- ___ Somewhat below average
- ___ Well below average

On average, how much time does your child spend on homework nightly? _____

Does your child participate in extracurricular activities? If yes, please list: _____

Has your child ever been evaluated for ADHD/other learning problems? If so, when, where and by whom? Why was evaluation done? _____

FAMILY HISTORY:

Who has been the primary caregiver of the child _____

Any significant separations during the first three years _____

How does the child get along with (mark the scale from 1-10 and explain why)

Mother: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details _____

Father: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details _____

Stepmother: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details _____

Stepfather: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details _____

Siblings: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details _____

Other: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details _____

Is there any family history of mental illness, developmental disabilities, alcohol/drug abuse, psychiatric treatment or hospitalization? If so, please specify/describe:

Has violence been a part of the marriage or any other important relationship in the child's life? Yes /No

If YES, please describe _____

Is there currently any physical violence or verbal abuse in your home? Yes /No

If YES, please describe: _____

Has your child been the victim of sexual, physical, emotional or verbal abuse?

Yes /No

If YES, please describe: _____

Significant Events in the Child's Life

Please circle Yes or No to all answers:

- 1. Death of a parent Yes/No
- 2. Parents' divorce Yes/ No
- 3. Parents' separation Yes/ No
- 4. Death of a close family member Yes/ No
- 5. Major personal injury or illness Yes /No
- 6. Illness of family member Yes/ No
- 7. Change of school Yes /No
- 8. Pregnancy Yes /No
- 9. Sexual problems Yes/ No
- 10. Death of a close friend Yes/ No
- 11. Serious relationship problems Yes/ No
- 12. Sibling leaving home Yes /No
- 13. Frequent change of residence Yes/ No

Please give the # of any Yes items and explain: _____

What would you like to get from your child's/your family's treatment here?

Parent's/Guardian's signature

Date