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/PREFERRED PRONOUNS_____

EMPLOYMENT STATUS Full-Time Part-Time None
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: _____

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 Self Harm
0 1 2 3 4 Feels Hopeless
0 1 2 3 4 Feels Worthless
0 1 2 3 4 Irritable
0 1 2 3 4 Sad/Tearful
0 1 2 3 4 Moody
0 1 2 3 4 Bully
0 1 2 3 4 Poor sleep
0 1 2 3 4 Too much sleep
0 1 2 3 4 Nightmares
0 1 2 3 4 Poor concentration
0 1 2 3 4 Excessive worry/fears
0 1 2 3 4 Panic
0 1 2 3 4 Irregular eating habits
0 1 2 3 4 Weight preoccupation
0 1 2 3 4 Nail biting
0 1 2 3 4 Repetitive behaviors
0 1 2 3 4 Thumb sucking
0 1 2 3 4 Soiling in pants
0 1 2 3 4 Bed wetting
0 1 2 3 4 Attention seeking

0 1 2 3 4 Hears Voices
0 1 2 3 4 Sees things not there
0 1 2 3 4 Fits of rage
0 1 2 3 4 Overly suspicious
0 1 2 3 4 Few friends
0 1 2 3 4 Excessively shy
0 1 2 3 4 Bossy
0 1 2 3 4 Overly sensitive
0 1 2 3 4 Teases others
0 1 2 3 4 Teased by others
0 1 2 3 4 Cruel to others/animals
0 1 2 3 4 Lying
0 1 2 3 4 Stealing
0 1 2 3 4 Fire setting
0 1 2 3 4 Runs away
0 1 2 3 4 Aggression
0 1 2 3 4 Truancy
0 1 2 3 4 Sexual acting out
0 1 2 3 4 Legal problems
0 1 2 3 4 Authority conflicts
0 1 2 3 4 Tics
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**