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Child/Adolescent Intake Questionnaire

(Please answer the following questions to the best of your knowledge. For children, parents please complete applicable questions. Teenagers and parents may wish to complete all or portions of the questionnaire together.)

Client Information:

Name: _____ Date of Birth: _____

 Last First Middle

Gender: Male _____ Female _____ School _____ Grade _____

Person(s) completing the form: _____ Date: _____

Relationship to Client: _____

Home Address: _____

Phone Numbers: (home) _____ (cell) _____

Referred By: _____

Insurance Information:

Insurance Company(s) Name & Address: _____

Name of Insured: _____ Insured's ID Number: _____

Group #: _____ Customer Service Phone #: _____

Employer: _____

Client Name: _____

Family Information:

Father's Name: _____ Age: _____ Mother's Name: _____ Age: _____
Occupation: _____ Occupation: _____
Education: _____ Education: _____
Address: _____ Address: _____
Home Ph: _____ Home Ph: _____
Cell Ph: _____ Cell Ph: _____

Guardian's Name (if other than a parent): _____
Address: _____
Home Ph: _____ Cell Ph: _____

Emergency Contact: (Other than parents or guardian)
Name: _____ Relationship: _____
Address: _____
Home Ph: _____ Cell Ph: _____

Primary Care Physician: _____ Off. Phone: _____

History:

Please describe why you are seeking services for your child/teen at this time: _____

When did the issue(s) begin? _____

What have you tried to resolve the issue(s)? _____

What changes have you noticed in the family since the issue began? _____

Client Name: _____

Do both parents see the issue(s) in the same way? If not, please explain: _____

Does your child/teen agree that there is a problem? If so, how does the child/teen see it? _____

Please describe your child's present living situation (w/parents, step-parent, siblings . . .) and his/her response to it: _____

What major changes, if any, have you experienced in your family over the past few months or years (moves, family member make up, income level, employment, etc.)? _____

Has a separation or divorce occurred within the family? If so, when: _____

Reaction of the child/teen: _____

Frequency the child/teen sees the other parent: _____

If child/teen is adopted, state any information of significance: _____

Has there been domestic violence among family members, past or present? If yes please describe: _____

Client Name: _____

Has your child/teen experienced any traumatic events in the past (i.e., significant injuries, major illnesses, deaths, other losses)? If yes, please describe: _____

Has your child/teen experienced emotional, physical, or sexual abuse? If so, please provide information regarding the type of abuse(s) and what has been done about it? _____

Please check any of the following factors which you think may be an issue for your child/teen or contribute to his/her current situation:

- | | |
|---|--|
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Behavioral problems |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Sibling rivalry |
| <input type="checkbox"/> Language problem | <input type="checkbox"/> Substance abuse in the household |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Parental conflict |
| <input type="checkbox"/> Giftedness | <input type="checkbox"/> Parental disagreement regarding parenting |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Parental absence |
| <input type="checkbox"/> Reading problems | <input type="checkbox"/> Lack of playmates |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Difficulty making and keeping friends |
| <input type="checkbox"/> Difficulty with eating/food | <input type="checkbox"/> Difficulty with sleep/nightmares |
| <input type="checkbox"/> School refusal | <input type="checkbox"/> Bullying others |
| <input type="checkbox"/> Peer conflict | <input type="checkbox"/> Bullied by others |
| <input type="checkbox"/> Difficulty with alcohol or drugs | <input type="checkbox"/> Gender identity issue |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Unreasonable fear(s) |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Harming animals |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Other |

Please provide the approximate ages the child/teen was able to:

Crawl _____ Walk _____ Talk _____ Toilet train _____

Any problems prior to or during the child's/teen's birth? If so, please describe: _____

Client Name: _____

Any developmental difficulties? If yes, please describe? _____

How does your child/teen feel about school? _____

How are your child's/teen/s grades this year? _____ Last year? _____

Favorite subject(s)? _____ Least favorite subject(s)? _____

Does your child/teen participate in any nonacademic activities? If so, please list: _____

What does your child/teen like to do in his or her free time? _____

What religion or philosophy/belief is acknowledged/practiced in your household and are there any conflicts present in this regard? _____

How would you describe your child/teen's personality? _____

What would you say are your child's/teen's strengths? _____

_____ limitations? _____

What type(s) of discipline(s) is used in the home: _____

List any work experience your teen has had: _____

What college or vocational plans does your teen have: _____

Does your child/teen have a history of previous psychiatric inpatient admission? If yes, please describe: _____

Client Name: _____

Does your child/teen have a history of previous outpatient therapies? If yes, when: _____

Does your child/teen presently have suicidal thoughts or a history of references to or attempts at suicide?

If yes, please describe: _____

Does your child/teen exhibit any self-harm behaviors? If yes, please describe: _____

Please list any medical conditions and medications taken (past & present) _____

Please list any psychiatric medications prescribed and taken (past & present) and the results: _____

Please provide a brief description of your child/s/teen's family psychiatric or emotional history (if known) and any other additional information you feel is relevant to your child/s/teen/s needs or treatment (it is not required that you fill the entire space provided.): _____
