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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:

_____Hearing problems
_____Speech problems
_____Language problem
_____Mental retardation
_____Giftedness
_____Learning disability
_____Reading problems
_____Distractibility
_____Difficulty with eating/food
_____School refusal
_____Peer conflict
_____Difficulty with alcohol or drugs
_____Irritability
_____Anxiety
_____Hyperactivity
_____Fire setting
_____Behavioral problems
_____Sibling rivalry
_____Substance abuse in the household
_____Parental conflict
_____Parental disagreement regarding parenting
_____Parental absence
_____Lack of playmates
_____Difficulty making and keeping friends
_____Difficulty with sleep/nightmares
_____Bullying others
_____Bullied by others
_____Gender identity issue
_____Sadness
_____Unreasonable fear(s)
_____Harming animals
_____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.):_____
_____
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