Child/Adolescent Intake Questionnaire

Today's Date ____________

Child/Adolescent's Name ___________________ Date of Birth _____ Age ____

Parent or guardian ________________________ Date of Birth _______

Current address____

Who gave you my name to call? ____________________ Phone __________

May I acknowledge the referral? ___________

Person providing information: _________________ Relationship to child ______

Who does child live with: __ both parents __mother __father __other

Biological father _____________ Occupation _________ Years education _____
Home phone __________ Work # ___________ Cell #_____________________
Email ____________________

Biological mother ____________Occupation __________ Years education ____
Home phone _________ Work # ____________ Cell # ____________________
Email ______________________

Please list all people in child's immediate family:

Name	Relation to child	Age/Grade	Living in house?

Language(s) spoken at home _____________ Primary language at home _____

Who should I contact in case of emergency (include name and phone)

____

Are biological parents of child currently: __married __separated __divorced
__never married

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Family History

Is there a family history for the following problems?	Biological family member with the history (parent, sister/brother,aunt)
__Learning Difficulties	
__Speech or Language problems	
__Developmental Disoder	
__Emotional issues (e.g. anxiety)	
__ADHD	
__School failure	
__Drug or Alcohol Addiction	

If separated or divorced, who has legal custody? __mother __father __other

Who has physical custody? __mother __father __other

Are there other adults who have a *significant* part in raising your child? __yes __no If yes, please describe: ____

Chief Concerns

Please describe the main difficulties that brought you to see me:

____

____

What help are you hoping to receive ___________________________________

____

Have there been any significant changes in the home over the last few years? (Such as new marriages, deaths, births, address changes, parent job change, etc.)

____

What do you feel are your child's
Strengths ____
Weaknesses ____

Previous Treatment

Has your child ever received psychological, psychiatric, drug or alcohol treatment or counseling services before? __Yes __No If yes, please explain:

____

____

Developmental History

Is child your: __biological child __adopted __foster __other

Birth weight ______ Premature? ____ Full term? _____ Overdue? _____

Any problems with pregnancy or delivery? ______________________________

Condition of child at birth ____

Child was: breast fed? ______ bottle fed? ______ Any difficulties? ________

Toilet training: bladder training completed at _______ bowel training _________

Describe any special problems during infancy ____________________________

Age at which child crept ______ walked _____ first word ___ sentences ______

Any speech or language concerns?

____

Any reading difficulties? ____

Any bedtime or sleeping problems? ____________________________________

Medical History

Name of physician ______________________________ Phone __________

Describe the state of your child's current health: __Excellent __Good __Fair __Poor

Dates of: last physical _______ hearing exam ______ eye exam ________

Has your child ever had: __ eye/visual problems __ear/hearing problems

__high fever __head injury __seizures/convulsions __allergies

Any severe disease, injuries or surgeries: _______________________________

List all medications and supplements being taken: ________________________

Date(s) and reasons for any hospitalizations ______________________________

Has your child shown any of the following (check all that apply)

__bedwetting __stealing __sleep walking __lying

__bad dreams __fear of school __eating problems

__persistent fears or worries __nausea or vomiting __anger outbursts

__shyness __nail biting __hair pulling __reading problems

__overactive behavior __truancy from school

__cigarette, alcohol or drug use

School/Day Care

Name of school ____

Current grade ______ Teacher _________________________________

Has your child participated in any special education programming? __yes __no

If yes, please describe ____

____

List (in order) daycare centers and schools your child has attended to the present time:

____

____

Other

Does your child smoke cigarettes? ____ How much? ______________

Does your child drink alcohol? ______ How much? ______________

Does your child use drugs? ______ What kind? ______________

Has your child ever been arrested? ____________

Is your child coming to see me related to an accident or injury? ___________

Any other questions or concerns you have? _________________________

____

____