Child & Adolescent Intake Questionnaire

Child’s Name: ___________________________ Date of Birth: ___________ Grade: ________
Person completing this form: ______________________________________________________
What school does your child attend? ________________________________________________

What has prompted you to seek treatment for your child now? ________________________________

________________________________

________________________________

________________________________

________________________________

Please list any specific symptoms you are noticing such as low mood, angry outbursts, worry, etc. ___________
________________________________

________________________________

________________________________

How long has your child had these symptoms? ____________________________________________
Has he or she had any prior psychological treatment? _______ If yes, when, with whom, and for how long? ____________________________________________

FAMILY INFORMATION

Are parents married, separated, or divorced? ____________________________________________
If divorced, who has legal custody of the child? __________________________________________
With whom does the child live? ______________________________________________________
Name of Child’s Mother: ___________________________ Occupation: ________________
Name of Child’s Father: ___________________________ Occupation: ________________

Is there anything notable, unusual, or stressful about the child’s relationship with either parent? _____
________________________________________________________________________________

Child’s siblings and others who live in the household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Client’s relationship with this person:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Good Average Poor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Good Average Poor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Good Average Poor</td>
</tr>
</tbody>
</table>

Is there a family history of alcoholism or drug abuse? ______ If yes, please describe: ____________

Is there a family history of mental health problems? ______ If yes, please describe: ____________

What stressful life events has your child or the family experienced in the past year? ____________

________________________________________________________________________________
DEVELOPMENTAL HISTORY

While pregnant, did the mother experience any traumas or stressful situations? ______
If yes, please describe: __________________________________________________________

While pregnant, did the mother use drugs or alcohol? ______
If Yes, please describe?

Was the child born at full term? ______ If no, how early was the child?____________________

Describe any complications during the pregnancy or during/after the delivery: ________________________

Was there anything notable about the child’s environment or care during their first year of life?______

Did your child meet developmental milestones (sitting, crawling, walking, talking, etc.) at appropriate ages? ______ If early or late, please describe: __________________________________________

Are there any circumstances you feel have negatively affected your child’s development? (e.g. poor nutrition, chaotic environment, neglect, a serious illness, etc.) __________________________________

Has your child experienced a death or loss? (family member, pet, friend moving) _________________
If Yes, please describe: _________________________________________________________________

TRAUMA

Has your child ever experienced abuse (physical, sexual, or verbal) or a trauma of any kind? (i.e. car accident, harsh punishment, surgery, etc.) _____ If yes, please describe: __________________________________________

SOCIAL HISTORY

Does your child have a history of difficult friendships, can make friends but not keep them, or tends to be off-putting to other kids in some way? ______ If yes, please describe: __________________________________________

Does he or she tend to have lots of friends at any given time or just a few close friends? __________

Are you concerned about your child’s social well-being? _____________________________

Has your child ever used drugs or alcohol that you know of? _____ If yes, please describe briefly: __________________________________________________________________________________________

SCHOOL HISTORY

How does your child feel about school? _____ Loves it _____ It’s okay _____ Hates it
Have there been any recent changes in the child’s grades?______ If yes, please describe: __________

Has the child ever been tested for a learning disability? ______ If yes, when and what were the results?
Is there much conflict between you and your child over homework? __________________________
Academically, my child does well in: ____________________________________________________________
My child struggles academically with: __________________________________________

Does your child worry about taking tests? ______

What are your expectations for your child academically? ________________________________

If your child misses school regularly for reasons other than illness, what are those reasons? ______

Other comments about school? ______________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

PHYSICAL HEALTH

Does your child have any other health concerns? If yes, please describe. ______________________

__________________________________________________________________________________

__________________________________________________________________________________

When was his or her last physical? ______________________________________________________

Does your child get regular exercise? ______

Does your child spend time outdoors regularly? ______

Is your child involved in a sport(s)? _____________________________________________________

Does he or she take any medications? ______ If yes, please list below.

Name and purpose of medication: Dose: Age/date began taking:
1.) _______________________________________________________________
2.) _______________________________________________________________
3.) _______________________________________________________________
4.) _______________________________________________________________

Who is the prescribing physician? _____________________________________________________

How would you describe your child’s quality of sleep? _________________________________

__________________________________________________________________________________

__________________________________________________________________________________

FAITH AND SPIRITUALITY

Do you want faith/spirituality to be a part of therapy? _________________________________

Does your child attend a church? _____________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

HOME LIFE

How would you describe the atmosphere of your home on most days? __________________________

__________________________________________________________________________________

__________________________________________________________________________________

Does your child have household chores? ______

If your child has siblings, would you describe their amount of fighting as normal? ____________

If no, please explain briefly: __________________________________________________________

__________________________________________________________________________________

How often are meals eaten together? ___________________________________________________

Does your child fall to asleep easily on their own? Y N If not, please describe: ______________

__________________________________________________________________________________

__________________________________________________________________________________

Does your child respect your authority most of the time or is it challenged often?

How much screen time is your child allowed on school days? _____________________________
on weekends? _________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
Does your child have a pet? ______ If yes, what type/name? ____________________________________

PARENTING

How are you feeling with regard to your child’s current issues? Check all that apply:

____ Helpless  ____ Frustrated  ____ Overwhelmed  ____ Confused  ____ Angry

____ Worried  ____ Concerned  ____ Hopeless  ____ Other: __________________________

How would you describe your parenting style? ____________________________________________

And your child’s other parent? ________________________________________________________

Do you have specific concerns about parenting? ______ If yes, what are they? ________________

__________________________________________

GOALS FOR THERAPY

What are your goals for your child’s therapy?

1.) ________________________________________________________________

2.) ________________________________________________________________

3.) ________________________________________________________________

Are you willing to be a part of your child’s therapy if necessary? ________

What do you consider to be your child’s strengths? ____________________________

__________________________________________

Is there anything else you want me to know about your child? __________________________

__________________________________________

__________________________________________

__________________________________________

Thank you for taking the time to fill this out. Please bring it with you to the first, parents only, appointment. I look forward to meeting with you!