Child & Adolescent Intake Questionnaire

Today's Date: _____ Birthdate: _____

Name of Client: _____ Age: __ Gender: _____ Person

Completing This Form: _____ Relationship: _____

Primary or Referring Doctor: _____

Personal Information

Client's Address: _____

Home Phone: _____Cell Phone: _____Child's Phone: _____

Client's School: _____ District: _____ Grade: _____

School's Phone Number: _____ Is the Clinician Able to Contact the School: _____

Client Employed: _____ Where: _____

Family Constellation

Parent/Guardians: _____

Who has legal custody of Child? Parents Mother Father Grandparents DCFS Other: _____ Are there any custody considerations of which the clinician should be aware?: _____ Who Has Decision Making Authority of Behavioral Health: _____

Visitation: _____

Age at Separation: _____

Copy of most recent Custody Arrangement must be provided for file prior to scheduling the first session.

Is child adopted? _____ If Yes, where and at what age? _____

If child is adopted, what does the child know about the adoption and / or birth family? _____

_____

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Household

Name:	Relationship	Age	Relationship Quality

Family Living Outside the Household

Parent/Mother's Name: _____ Date of Birth: _____

Address (if different than page 1): _____ _____

Education: _____ Occupation: _____ Work Hours: _____

Employer Name / Location: _____ _____

Do you travel for work? _____ How often? _____

Parent/Father's Name: _____ Date of Birth: _____

Address (if different than page 1): _____ _____

Education: _____ Occupation: _____ Work Hours: _____

Employer Name / Location: _____ _____

Do you travel for work? _____ How often? _____

Have there been any recent family changes? (describe): _____

Describe Parenting Approach: _____ _____

Disciplinary style: _____

Is there a particular form of discipline that has proven to be effective? _____

Is there a particular form of discipline that seems to not be effective with your child? _____

Have you every participated in a parenting class or obtained other forms of information concerning discipline and behavior management? _____

DCFS Involved? _____ When/Why? _____

Prenatal and Development History

Complication	Yes	No	Describe if Yes
Excessive Vomiting			
Hospitalization Required			
Threatened Miscarriage			
Infections (specify)			
Toxemia			
Operations			
Other Illnesses			
Smoking during pregnancy			
Alcoholic consumption during pregnancy			
Medications taken during pregnancy			
Exposure to illicit drugs			
X-Ray studies during pregnancy			

Delivery: Birth Weight _____ APGAR Score: _____

Circle all that apply.

Type of Labor: spontaneous Induced Type of Delivery: Normal Breech Caesarean

Complications: Cord Around Neck Hemorrhage Infant injured in delivery Other: _____

Post Delivery Period: Number of days infant was in hospital after delivery _____

Jaundice Cyanosis (infant turned blue) Incubator Care Infection (Specify) _____

Infancy Period: Were any of the following present, to a significant degree, during the first few years of life? If so, describe:

	Yes	No	Describe if Yes
Did not enjoy cuddling			
Was not calmed by being held or stroked			
Difficult to comfort			
Colic			
Excessive restlessness			
Excessively irritable			
Diminished sleep			
Difficultly nursing			
Constantly into everything			

Overall Infant Temperament: _____

Medical History

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any pertinent information:

	Yes	No	Describe if Yes
Childhood Disease			
Operations			
Hospitalizations for Illness			
Head injuries			
Convulsions (with/without fever)			
Coma			
Eye problems			Date of Last Exam
Earing problems			Date of Last Exam
Allergies			
Asthma			
Poisoning (lead)			
Sleep Disturbances			
Eating difficulties			

Present Medical Status:

Height: _____ Weight: _____ Date of Last Physical Exam: _____

Present Illness for which child is being treated? _____

Please list ALL current medications (include birth control, over the counter medications and herbal remedies – i.e. decongestants, St. John's Wort, etc).

Name of Medication	Dosage (mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing Physician

Developmental Milestones

If you could recall, record the age at which your child reached the following developmental milestones.

Milestone	Age Reached	Difficulties?	Response to difficulties
Crawled			
Walked			
Spoke first words			
Said phrases			
Bladder trained – day			
Bladder trained – night			
Bowel trained – day			
Bowel trained – night			
Buttoned Clothing			
Tied Shoelaces			
Began to read			

Coordination

Please rate your child on the following skills (Good – Average – Poor):

	Good	Average	Poor
Walking			
Running			
Throwing			
Catching			
Shoelace tying			
Buttoning			
Writing			
Athletic abilities			

Support Systems

Circle all that apply.

Friends: Close Friends Group of Friends Family Extended Family Religious Group Self-Help Group Clubs/Sports Other: _____

Does your child seek friendships with peers? Yes No

Is your child sought out by peers for friendships? Yes No

How does your child respond to this? _____

Does he/she seem affected or act as if this is not if interest to him/her? _____

Does your child play with children primarily his or her: Own age Younger Older

Does your child get along with peers: _____

Describe briefly any problems that your child may have with peers: _____

History of Bullying: _____

School

Name of School	Grade/s Attended	Reason for Change of School

Present class placement: Regular class Special classes (Type): _____

How are your child's grades? _____

Has your child ever had to repeat a grade? If so, what grade and why? _____

Kinds of special counseling or remedial work that your child is currently receiving _____

_____

Describe any academic/behavioral school problems: _____

Challenges

Present psychological difficulties of your child	Yes	No
Generalized anxiety		
Specific fears/phobias: (list)		
Panic attacks		
Social anxiety		
Obsessive thinking or compulsive behaviors: (list)		
Body-focused repetitive behavior: (skin picking, hair pulling, nail biting)		
Sadness or depression		
Emotionally overwhelmed		
Frequent crying		
Loss of energy		

Loss of pleasure in life		
Self-injurious / self-harming behavior		
Thoughts of suicide		
Problems with eating		
Problems with falling asleep		
Problems sleeping through the night: (falling, staying, waking early)		
Trouble waking up		
Fatigue/tired during the day		
Nightmares		
Problems with attention/concentration		
Hearing strange voices		
Racing thoughts		
Memory lapses		
Problems making of keeping friends		
Problems controlling temper		
Physical illness		
Eating disorder		
Romantic Relationship problems		
Problems with job		
Problems with school		
Hopelessness		
History of abuse (physical, emotional, sexual)		
Alcohol/drug use or abuse		
Legal problems		
Grief/mourning		
Pain		
Hallucinations		
Guilt		
Worry		
Mood swings		
Codependency		
Repetitive thoughts		
Loneliness		
Perfectionism		
Rapid Speech		
Impulsiveness		
Fire setting		

Running away		
Destruction of property		
Harming others		
Cruelty to animals		
School suspensions		
Unwanted thoughts		
Having to do things over and over again		

Other current challenges or areas of concern:

Describe your reason for coming in today and why now?

Positive Qualities/Strengths

Which of these qualities does your child have?	**Yes**	**No**	**Sometimes**
Creativity			
Curiosity			
Love of learning			
Wisdom/perspective			
Bravery			
Persistence			
Integrity			
Vitality			
Love			
Kindness			

Social intelligence			
Fairness			
Leadership			
Forgiveness/mercy			
Humility/modesty			
Self-control			
Appreciation of beauty/excellence			
Gratitude			
Hope			
Humor/playfulness			
Spirituality			

Other positive qualities: _____

_____

What are your child's main hobbies and interests? _____

_____

What are your child's areas of greatest accomplishments? _____

_____

What does your child enjoy doing most? _____

_____

What does your child dislike doing most? _____

_____

Previous Treatment

Current Therapist: (Name/ Contact Phone #): _____

Previous Therapist / Psychiatrist: (Who, When, Purpose?): _____

_____

Previously Treated For:

Bipolar (Manic/ Depressive) Disorder Depression ADHD Anxiety OCD Schizophrenia
Panic Attacks PTSD Alcohol Problems Anorexia/Bulimia/Binge Eating ECT treatment
Drug Problems

Has your child ever been psychiatrically hospitalized? Yes No
Previous Hospitalizations:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Has your child ever attempted to harm/kill him/herself? Yes No

Approximate Date	How did he/ she attempt (Method)?

Previous Occupational Therapy (When, Purpose): _____

Physical Therapy (When, Purpose): _____

Speech Therapy (When, Purpose): _____

Vision Therapy (When, Purpose): _____

Psychological Evaluation (When, Purpose, Findings): _____

_____

Academic/Tutoring: _____

Other: _____

Family History

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self-mother, father, sibling, etc)

Yes	Condition	Family Member
	Mental retardation	
	Speech or communication disorder	
	Attention-deficit/hyperactivity/impulsivity	
	Learning problems / disabilities	
	Autism spectrum/asperger's disorder	
	Sleep disorders	
	Generalized anxiety	
	Social anxiety	
	Obsessive-compulsive disorder	
	Phobias	
	Depression	
	Manic-depression/bipolar disorder	
	Suicide attempts/suicide	
	Schizophrenia or other psychosis	
	Alcohol/ substance abuse	
	Seizures or other neurological disorder	
	Genetic disorder (Down Syndrome, Fragile X)	
	Other:	

Has your child experienced in the past or currently have any medical difficulties?

Health Habits and Personal Safety

Exercise: Sedentary (No exercise)

Mild Exercise (climb stairs, walk 3 blocks, golf)

Occasional Vigorous exercise (work or recreation, less than 4x/week for 30 mins)

Regular Vigorous exercise (work or recreation 4x/week for 30 minutes)

Diet: Is your child dieting? Yes No

If yes, is your child on a physician prescribed medical diet? Yes No

# of meals eaten in an average day?_____

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Caffeine: None Coffee Cola Energy Drinks Other

# of cups/cans per day _____

Alcohol: None Some Use of alcohol is of concern

If Some or if alcohol is of concern, please describe: _____

Tobacco: None Some Use of tobacco is of concern

If some or if tobacco use is of concern, please describe: _____

Drug: None Some Use of drugs is of concern

If some or if drug use is of concern, please describe: _____

Sex: None Some Sexual behavior is of concern

If sexual behavior is of concern, please describe: _____

Goals: _____

_____

_____

Please provide any other information that might be helpful in understanding your child and family:

_____

_____

_____

_____

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