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 Custody Arrangement of File: ☐ Yes ☐ No

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: ______________________________

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Discipline: ____

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: ________________

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) __________

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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? ____

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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			

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Support Systems

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

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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		

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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?

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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? ____

____

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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 ☐ Other

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: ____

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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 of the following medical difficulties?

☐ Chronic Illness ☐ Chronic Pain ☐ Diabetes ☐ Auto Immune Disease ☐ High Blood Pressure

☐ Low Blood Pressure ☐ Thyroid ☐ Migraines ☐ Seizures ☐ Gastrointestinal ☐ Cancer

☐ Genetic Disorder ☐ Other:

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)

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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?______________________________

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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