Child/Adolescent Intake Questionnaire

Name: ____ Date: ________________________

Birth Date: ________________________ Gender: □ Male □ Female

Ethnicity: __________________________ Age: __________ Grade: ______________________

Presenting Problem(s)

Primary Complaint (Symptoms): ____

____

____

____

____

____

History of Complaint: ____

____

____

Previous Mental Health Treatment: ____

____

Previous/Current Diagnosis (Diagnosed By/Date): ____

____

Prescribed Psychotropic Medication (Prescribed By/Date): __________________________________

____

Background Information

Place of Birth (City, State, Country): ____

Primary Place of Residence: ____

____

____

Household Members (name, relationship, & age): ____

____

____

Primary language spoken in the home? ______________________ Other language(s): ______________

Current Educational Problems: ____

____

____

____

____

Medical Problems: ____

____

____

____

____

Mental Health Problems: ____

____

____

____

____

Substance Abuse Problems: ____

____

____

____

Traumatic Events, Self-Concept: ____

____

____

____

____

____

____

Perceived Strengths and Weaknesses: ____

____

____

____

____

____

____

Social Development: ____

____

____

____

____

No. of Peer Relationship(s): ________________ Prefers to Play Alone? □ Yes □ No

Hobbies and/or Sport Activities: ____

____

Unusual Fears or Behaviors: ____

____

Parental Information

Marital Status: □ Married □ Divorced □ Separated □ Deceased (Mother/Father)

If parent(s) are separated, divorced, or deceased, how old was minor? ____________________

Mother's Name:________________________ Age: ______ Level of Education:__________________

Occupation: ____ □ Full-Time □ Part-Time

Medical Problems: ____

____

____

Educational Problems:____

____

____

Mental Health Problems: ____

____

____

Substance Abuse Problems: ____

Quality of Relationship: ____

____

____

____

____

Father's Name: ______________________ Age: _____ Level of Education: ________________

Occupation: ____ ☐ Full-Time ☐ Part-Time

Medical Problems: ____

____

____

Educational Problems: ____

____

____

Mental Health Problems: ____

____

____

Substance Abuse Problems: ____

Quality of Relationship: ____

____

____

____

____

Sibling(s):

Medical Problems: ____

____

Mental Health Problems: ____

____

Educational Problems: ____

____

Substance Abuse Problems: ____

____

____

Quality of Relationship(s) with Sibling(s): ____

____

____

____

Developmental & Medical History

Development:

Duration of Pregnancy: ☐ Premature ☐ Full-Term ☐ Over Due

Type of Delivery: ☐ Normal ☐ Breeched ☐ Caesarean

Complications: ____

____

Birth Defects: ____

____

Developmental Milestones Reached: ☐ Early ☐ Normal ☐ Late

Describe: ____

____

____

Unusual or Sever Childhood Illnesses and/or Surgeries: ______________________

____

____

____

Social and Behavior Checklist

Place a check (√) next to any behavior or condition your child experienced in childhood.

	difficulties with speech		frequent tantrums
	difficulties with hearing		frequent nightmares
	difficulties with language		trouble sleeping
	difficulties with vision		rocked back and forth
	difficulties with coordination		banged head
	preferred to be alone		held breath
	did not get along well with siblings		ate poorly
	aggressive		stubborn
	shy or timid		delayed toilet training
	more interested in things than people		lethargic
	engaged in dangerous behavior		clumsy
	impulsive		had blank spells
	bedwetting		sucked thumb
	nail biting		hyperactive

Educational History: Place a check (√) next to any educational problem your child experienced in school or continues to experience:

	difficulty with reading
	difficulty with arithmetic
	dificulty with spelling

	difficulty with writing
	difficulty with concentration
	difficulty with other subjects:

Special Education Class? ____

Skip or Repeat Grade(s)? ____

Notes: ____