



CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

*It is Important to complete this in its entirety and to have it with you at the time of first appointment

Date _____

Child's Name _____ Age _____ Grade _____

Your Name _____ Relationship to Child _____

Presenting Problem

1. What is your major concern that led you to seek help?

2. What other concerns do you have?

3. Is there a particular reason you are seeking an appointment now?

Psychological History

4. Has the child ever had a psychological evaluation or had intellectual or achievement testing? Y N
If yes, describe when, with whom and what the results were. (Please attach any evaluations that have been done for your child).

5a. Has the child ever been seen by a psychiatrist, psychologist or counselor, or have you ever sought help for these problems before? Y N

5b. If yes, please write name(s) and address(s) of professional(s).

5c. Explain what happened and result for each.

Medical Information

6. Name and address of your child's current physician or pediatrician.

7. What is your child's current health? Is the child being treated for anything?

8. Has your child ever taken medication for attention, behavior or mood problems? Y N

9. Please indicate any medications your child is currently taking or has taken.

Medication			
Dosage			
Purpose			
Date Started & Ended			
Physician			
Side Effects (if any)			

10. Explain your child's eating habits, restricted diet, food or eating limitations, weight concerns. Has the child ever been tried on any special diets? _____

11. What physical or exercise activities is your child involve in?

12. (Adolescent females only) What problems, if any, does your child have with unusual depression, irritability or discomfort during her menstrual cycle?

13. Please indicate any of the following sleep problems that your child has, (if any), by rating the severity of the problem; Mild, Moderate, Severe.

_____ Difficulty waking in the morning _____ Frequent waking during night _____ Snoring
_____ Difficulty falling asleep _____ Nightmares (bad dreams) _____ Bedwetting
_____ Not rested after sleep _____ Sleeping too much _____ Delaying bedtime
_____ Physically restless sleep _____ Teeth grinding

14. Has your child suffered any of the following?

Problem	Explain frequency, age, etc.
Serious Illness	_____
High Fever	_____
Convulsions	_____
Operations	_____
Accidents	_____
Unconsciousness	_____
Allergies	_____
Hospitalizations	_____
Vision Problems	_____
Hearing Problems	_____
Head Injury, Concussion	_____

15. Are there any current physical problems? Y N If so, explain _____

16. Has your child had any physical symptoms/problems to a bothersome degree such as: asthma, pneumonia, fainting spells, vomiting spells, dizzy spells, nose bleeds, constipation, frequent colds, earaches, headaches, diarrhea, and/or stomach complaints?

17. Would you say your child was sickly? Y N If so, explain _____

18. Any other information that would be of help? _____

Family History

19. Does your child or any family member have or had any of the characteristics listed below please indicate and write in their relationship to the child. (Ex. father, mother, grandfather, aunt, etc.; if unknown please state)

	Child	Other Relatives
Reading difficulties	_____	_____
Spelling difficulties	_____	_____
Left handedness	_____	_____
Speech difficulties	_____	_____
Math difficulties	_____	_____
Writing problems	_____	_____
Hyperactivity	_____	_____
Attention problems	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Sleep disorder	_____	_____
Obsessive Compulsive	_____	_____
Mood swings	_____	_____
Anger Management	_____	_____
Addictions (alcohol, drugs)	_____	_____
Violent or criminal behavior	_____	_____
Migraines/headaches	_____	_____
Seizures	_____	_____

Developmental History

20. Pregnancy

Was child adopted? Y N If so, at what age? _____
Was Assisted Reproductive Technology (ART) involved in your child's conception? Y N If so, what means?

Any illnesses during pregnancy? _____
At what stage of pregnancy? _____
Any medication taken by mother? _____
RH Factor? Y N Was child transfused? Y N

21. Birth

How many weeks pregnant did you give birth? _____ Birth weight _____
Was labor prolonged? (12 hours or more) _____
Was this a Caesarean section? Y N
Was there birth trauma? (forceps, breech, anoxia) _____
Was your child placed in an incubator? Y N Explain _____
If so, explain _____
Was the child discolored at birth? Y N Explain _____
If so, explain _____
Were there any medical problems after birth? _____

Released from hospital after _____ days.

22. Childhood

When did your child walk without assistance? _____
When did your child speak? Words _____ Phrases _____ Sentences _____
Any speech or language problems? Y N If so, explain _____

Was English your child's first language? Y N
At what age was toilet training accomplished? Bladder _____ Bowel _____
Explain any problems _____

Did bedwetting continue? Y N If so, how long? _____
Any separations from family? Y N If so, at what age and explain reason _____

Was your child extremely physically active or always "on the go"? Y N
Were there any disruption or major difficulties that could have affected the child's bonding with his or her mother during the first three years? Y N If so, please explain. _____

23. Has the child shown any of the following?

Temper tantrum	Y	N	Persistent thumb sucking	Y	N
Unusual fears	Y	N	Walking in sleep	Y	N
Eating problems	Y	N	Accident prone	Y	N
Rocking/head banging	Y	N	Extremely physically active	Y	N
Clumsiness	Y	N			

Explain _____

23A. Has your child ever suffered a head injury, concussion or traumatic brain injury (tbi)? If yes, explain _____

Home Life

24. What are the child's current living conditions? If the parents, are divorced, who has custody and what are the visitation agreements? _____

25. How well does your child get along with his/her parents?

Mother/StepMother _____

Father/Step Father _____

26. If the child is not living with both natural parents, what is his/her relationship with the non-custodial parents? _____

27. If birth parents are not together, how well do they get along, especially in regards to your child? _____

28. Do parents agree on discipline? Y N If not, explain _____

29. Who disciplines your child at home and how? _____

30. List any other children in the child's family or any other person's living in the home.

Name	Relationship to child	Birth date	Living in home?

31. How well does the child get along with siblings? _____

32. Is there a set time and place for your child's homework activity? Explain _____

33. How much time does your child usually spend doing homework on a school night?

30 mins. or less 1 hour 2 hours 3 or more hours

34. From after school until bedtime, how much time does your child usually spend watching television?

5 hours or more 4 hours 3 hours 2 hours 1 hour or less none

35. If your child plays video games, how much time is spent per day?

5 hours or more 4 hours 3 hours 2 hours 1 hour or less none

36. If your child plays video games, what is the highest rating level that your child plays?

EC (Early Childhood) E (Everyone) T (Teen) M (Mature) A (Adult)

37. How many hours does your child usually spend on leisure reading after school?

5 hours or more 4 hours 3 hours 2 hours 1 hour or less none

38. What is/are your child's chores/responsibilities at home? _____

39. Does your child participate in sports or demonstrate any special talents? _____

School

40. Did your child attend nursery school, day care, or private kindergarten? Y N

41. How did your child adjust to the above experience? Liked _____ Disliked _____ Resisted _____

Please explain _____

42. Is your child currently on an individualized Education Plan (IEP)? Y N
If so, please attach most recent IEP.

43. Specify any private tutoring or summer school that was pursued. _____

44. Please describe your child's greatest strengths and any special abilities or talents. In what school subjects has he or she generally done best? _____

45. Has your child ever repeated a grade? Y N If so, list grade and explain. _____

46. Has your child learned as well as expected? Y N If no, explain _____

47. Does your child get along well with other students? Y N If no, explain _____

48. Does your child get along well with teachers? Y N If no, explain _____

49. Is there a set time and place for your child's homework activity? Y N Explain _____

Psychosocial History

50. How does your child get along with friends and peers? _____

51. Does your child have problems either understanding or expressing emotions? Does your child have problems with social awareness? _____

52. To your knowledge, has your child used tobacco, alcohol, marijuana or other drugs? Y N
If so, explain _____

53. Any problems in social network such as death or loss of close friends, rejection by peers, or frequent moves causing loss of friends? _____

54. Educational problems including learning problems, problems with teachers or classmates, ridicule or bullying? _____

55. Problems with housing, living arrangements or sudden loss of family income? _____

56. Medical problems, illness or surgeries? _____

57. Problems related to the police, or interaction with legal system, being a victim or a crime or a ward of the court? _____

58. Exposure to a disaster, accidents or other trauma? _____

59. Problems in family such as separation, divorce or remarriage of a parent; psychiatric, alcohol or drug problems of parent or sibling, death or serious health problems of a family member, change in living arrangements? If so, list age of child, nature and affect it had on the child. _____

60. Any emotional, physical or sexual abuse; neglect, or exposure to domestic violence? If so, list age of child, nature and affect it had on the child. _____

61. What are your child's hobbies, interests or activities?

Attention Problems

62. What problems, if any does your child have with daydreaming, staying on-task or being disorganized? At what age did you first notice this? Do the problems occur mainly at home, at school, or in both places? _____

63. What problems, if any, does your child have with hyperactivity, stimulus seeking or feeling restless? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places? _____

64. What problems, if any does your child have with impulsivity or acting without thinking of consequences? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places? _____

Oppositionality, Anger and Conduct Problems

65. How cooperative is your child? If asked to do 5 things during a day, how many would they do correctly on the first request, without arguing or delaying? _____ How much do you feel the problem is with being defiant and uncooperative versus distractible or disorganized? _____

66. What problems, if any does your child have with irritability and anger? When angry, is the child more likely to let the anger go quickly or hold onto resentment? _____

67. Does your child ever become violent or destructive? Have they ever hurt anyone intentionally or threatened to kill someone? Have they ever been cruel to animals? What interest does the child have in weapons? _____

68. What problems, if any, does your child have with authority or with getting into trouble, unlawful activity or delinquent actions that could cause legal consequences? _____

69. In relating to others, what problems, if any, does your child have in terms of being cruel, manipulative or failing to show remorse when appropriate? _____

Depression

70. What problems does your child have with their feeling being too easily hurt? Are there any signs of problems with self-esteem? Are there particular things about him or her self your child feels bad about? _____

71. What problems, if any, does your child have with sadness, moodiness, withdrawing from friends or activities, looking unhappy, crying easily, or other signs of depression? _____

72. Has your child ever talked about wishing they were dead or discussed or attempted suicide? _____

Anxiety

73. What problems, if any, does your child have with fears, tension, anxiety, panic attacks, phobias, being very uncomfortable in new situations or extreme shyness? How has that changed over time? _____

74. How likely is your child to complain of not feeling well that may be related to stress or anxiety? _____

75. Does your child show intense fear, helplessness, upset or avoidance around anything that reminds them of any trauma such as having been a victim of, or witness to, violence, or having been in an accident? Y N
If so, please describe _____

76. Are there any ideas, fears or concerns about which your child obsesses or worries? _____

77. Does your child have any habits, rituals or other compulsive behaviors? _____

78. Does your child have any habits, rituals or other compulsive behaviors? _____

79. What problems does your child have with muscle or verbal tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming. _____

Other Problems

80. Does your child prefer to be alone or show little interest in having close relationships, with peers outside family (but not shy)? _____

81. Is your child's style of speech "odd" (too exact, unusual tone or too formal)? _____

82. Does your child tend to become overly fascinated by one particular topic or become an expert on one particular subject such that it is all they want to talk or learn about? (The topics may change as they become older) _____