CHILD / ADOLESCENT INTAKE QUESTIONNAIRE

IMPORTANT

Failure to answer all questions may result in the delay of appointment scheduling.
If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
NOTE: The information you provide is confidential and protected by law.

Date: _____

Demographic Information
Child's name: _____ Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Who referred you: _____

Why are you requesting services for your child?_____
_____

What concerns bring you here? *(check those that apply)*
Behavior Problems:
☐ Self-injurious behavior ☐ Lying/stealing ☐ Struggles socializing ☐ Clingy ☐ Rage
☐ Physical aggression ☐ Refusal to attend school ☐ Withdrawn ☐ Tearful ☐ Nightmares
☐ Verbal aggression ☐ Alcohol/drug use ☐ Other behavior of concern: _____

Emotional Distress:
☐ Depression/sadness ☐ Moodiness ☐ Suicidal/homicidal ☐ Death
☐ Anger ☐ Anxiety ☐ Psychotic-like symptoms ☐ Parents divorce
☐ Other: _____

Functional Problems:
☐ Poor hygiene ☐ Irresponsible ☐ Employment ☐ Concentration problems
☐ Problems with mobility ☐ Physical pain/injury ☐ High or low energy ☐ Poor organization skills
☐ Problems with hearing ☐ Impulse control ☐ Poor grades ☐ Unmotivated
☐ Problems with speech ☐ Social relationships ☐ Memory problems ☐ Lack of coordination
☐ Recognition of danger ☐ Sleep problem ☐ Learning problems ☐ Fine Motor problems
☐ Money management ☐ Eating problem ☐ Cognitive problems ☐ Feeding Aversion
☐ Safety problems ☐ Sensory problems ☐ Problems with play ☐ Difficulty chewing/swallowing (coughing, choking)

DEVELOPMENTAL HISTORY
Mother's age at time of the child's birth: _____

Was your child possibly exposed to alcohol or other substances during mother's pregnancy? ☐ Yes ☐ No

What were the complications or concerns during the pregnancy for the mother? ☐ None
(If any of the following occurred, please elaborate on condition/treatment.)
☐ Gestational diabetes ☐ Anemia ☐ Preeclampsia ☐ Placenta previa ☐ Toxemia ☐ Depression
☐ Sexually transmitted disease ☐ Heart disease ☐ Physical trauma ☐Premature labor ☐ Abuse
☐ Other: _____ ☐ Prescribed medications: _____
Was bed rest required? ☐ No ☐ Yes
If yes, please describe timeframe and reason: _____

Length of Pregnancy
☐ Full term ☐ Premature – born at how many weeks? _____ Birth weight _____
Place of Birth ☐ Hospital name_____ Location_____ ☐ home ☐ other

Was labor induced? ☐ No ☐ Yes, please describe the reason: _____
Length of labor _____ **Length of time pushing** _____

Mode of delivery: ☐ Vaginal ☐ Cesarean ☐ Emergency Cesarean

How many days was the baby in the hospital?_____

Were there any concerns or complications during/immediately following your delivery?

☐ Baby's heart rate dropped ☐ Cord wrapped around neck/umbilical cord
☐ Born "blue" ☐ Breech ☐ Low blood sugar
☐ Low Apgar scores ☐ Significant jaundice (bilirubin) ☐ IV fluids
☐ Difficulty sucking ☐ Oxygen
☐ Treatment in the NICU/special care unit – details:_____

Temperament as an infant: ☐ Easy ☐ Withdrawn ☐ Difficult ☐ Other: _____

Bonding: ☐ Cuddly ☐ Withdrawn ☐ Clingy ☐ Other: _____

Activity level as an infant/toddler: ☐ Average ☐ On-the-go ☐ Destructive ☐ Lethargic ☐ Accident prone

Apprehension with strangers: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Emotionally oversensitive/over-reactive as an infant: ☐ No ☐ Yes
Does this continue to be a problem? ☐ No ☐ Yes

Developmental milestones (check all that apply):

By 2-4 Weeks:

☐ Can sleep for 3 or 4 hours at a time ☐ On stomach, lifts head momentarily ☐ When crying, can be consoled most of the time, by being spoken to or held
☐ Responds to parent face/voice ☐ Can stay awake for >1 hour

By 2 Months:

☐ Coos/vocalizes ☐ Lifts head, neck, and upper chest w/support of forearms from stomach
☐ Smiles responsively

By 9 Months:

☐ Responds to name ☐ Crawls, creeps, or scoots ☐ Pokes with fingers, shakes, bangs, throws, drops objects
☐ Understands a few words ☐ Sits unsupported
☐ Babbles ☐ Plays peek-a-boo or pat-a-cake ☐ Feeds self with fingers

By 12 Months:

☐ Pulls to stand and may take a few steps alone ☐ Says 2-4 words, imitates vocalizations ☐ Waves "bye-bye"
☐ Looks for dropped or hidden objects ☐ Feeds self
☐ Drinks from cup ☐ Steps while holding on ☐ Brings toys/objects to show

By 18 Months:

☐ Walks backward ☐ Uses two-word phrases ☐ Follows simple directions
☐ Throws ball ☐ Uses a spoon and cup ☐ Points to some body parts
☐ Scribbles ☐ Shows affection, kisses ☐ Pulls a toy along the ground
☐ Watches face for reaction

By 24 Months:

☐ Goes up and down stairs one step at a time ☐ Stacks five blocks ☐ Follows two-step commands
☐ Uses at least 20 words, two-word phrases ☐ Imitates adults
☐ Kicks ball

By 5 Years:

☐ Dresses self without help ☐ Can count on fingers ☐ Recognizes most letters and prints some
☐ Learns address/phone number ☐ Copies basic shapes ☐ Speech is easily understood

By 11-18 Years:

☐ Sexual development and behaviors ☐ Peer relationships ☐ Social/emotional interaction
☐ Worries about grades

Toilet trained? ☐ Yes ☐ No (circle all that apply): Daytime wetting Nighttime wetting Bowel incontinence

Puberty: ☐ No ☐ Yes, started at age: _____ If female, first menstruation age: _____

Cares for self: ☐ Yes ☐ No ☐ With help (i.e. Bathing, Dressing, And Grooming) Comment:

_____

_____

MEDICAL HISTORY
Date of last physical examination: _____ Name of Physician:_____
Purpose of physical examination: _____
_____

Name of primary care physician & clinic name: _____
☐ **Major Surgery** (attach additional information/list if needed):
Procedure: _____ Procedure: _____
_____ _____
Age: _____ Age: _____
☐ No complications ☐ No complications
Complications: _____ Complications: _____
_____ _____
☐ **Medical Hospitalization** (attach additional information/list if needed):
Cause: _____ Cause: _____
_____ _____
_____ _____
Dates/Age: _____ Dates/Age: _____
☐ **Medical Diagnoses:**

1.	3.	5.
2.	4.	6.

Has the child ever experienced the following? If yes, please elaborate below. ***(check those that apply)***
☐ High fever requiring hospitalization or treatment: _____
☐ Unexplained fever or spike of temperature: _____
☐ Head injury: _____
☐ Concussion: _____
☐ Loss of consciousness: _____
☐ Seizures Type: ☐ Partial ☐ Partial complex ☐ Generalized
Beginning at what age: _____ Frequency: _____
☐ Tics or abnormal body movements: _____
☐ Thyroid or endocrine problems
☐ Chronic ear/sinus infections Were tubes required? ☐ No ☐ Yes, at what age(s): _____
☐ Strep throat ☐ Diabetes/blood sugar problems ☐ Meningitis, encephalitis
☐ Bronchitis, pneumonia ☐ Upper respiratory problems/asthma ☐ Allergies_____
☐ Other congenital conditions: _____
☐ Lead or other toxin exposure: _____

Please list currently prescribed medications:

	Medication	Dose	Frequency	Prescribing Physician
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Past medications that have produced a negative reaction/ineffective medications:

	Medication	Dates used	Reason for Discontinuation
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Current Medical Conditions/Illnesses (check those that apply)
Hearing: ☐ No problems ☐ Conductive impairment ☐ Sensory-neural impairment ☐ Hearing devices
Vision: ☐ No problem ☐ Nearsighted ☐ Farsighted ☐ Glasses ☐ Contacts ☐ Blind ☐ Other: _____
Speech: ☐ No problem ☐ Does not speak ☐ Speaks words, no sentences ☐ Words difficult to understand ☐ Stutters

Current Sleep
☐ Duration in hours: _____ ☐ Requires naps ☐ Midnight awakening ☐ Early awakening
☐ Difficulty falling asleep ☐ Other: _____
☐ Nightmares ☐ Frequency: _____ per week ☐ Content: _____
Eating
☐ No problems ☐ Obsessed with food – since: _____ ☐ Increased/decreased appetite – since: _____
☐ Weight gain/loss: Amount in pounds: _____ Since: _____
☐ Drooling ☐ Food falls from mouth ☐ Gags ☐ Eats limited types of food ☐ Has taste/texture sensitivities

PSYCHIATRIC HISTORY
☐ **Psychiatric hospitalization** Where: _____
Cause:_____ Cause: _____
_____ _____
Dates/Age: _____ Dates/Age: _____

Has the child been diagnosed previously with any type of developmental conditions?

☐ *ADHD/ADD* Date of diagnosis:_____ Type:_____ By whom:_____

☐ *Autistic spectrum disorder (autism, Asperger's syndrome, PDD.NOS) Circle one*
Date of diagnosis:_____ By whom:_____

☐*Cognitive impairment (mild / moderate / severe mental retardation) Circle one*
Date of diagnosis:_____ By whom:_____

☐ *Receptive / expressive / mixed speech delay Circle one*
Date of diagnosis:_____ By whom:_____

☐ *Learning Disability*
Date of diagnosis:_____ Type:_____ By whom:_____
☐ *Mental health Diagnoses*
Date of diagnosis:_____ Diagnosis:_____ By whom:_____

Allied Health Professional(s

Past mental health professional(s) Name Time Frame/Dates of Treatment
Psychologist(s): _____ _____
Psychiatrist(s): _____ _____
Neurologist(s): _____ _____
Other: _____ _____

Ever had psychological or neuropsychological testing? ☐ Yes ☐ No
By whom? _____ When? _____

Current mental health professional(s) Name Time Frame/Dates of Treatment
Psychologist(s): _____ _____
Psychiatrist(s): _____ _____
Neurologist(s): _____ _____
Other: _____ _____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past by the child or parent:

Current	Past		child	mother	father
☐	☐	Alcohol	☐	☐	☐
☐	☐	Marijuana	☐	☐	☐
☐	☐	Ecstasy	☐	☐	☐
☐	☐	Huffing (gas, aerosol, etc.)	☐	☐	☐
☐	☐	Other: ______________________			

Has the child ever attended a substance abuse treatment program? ☐ No ☐ Yes

FAMILY

Current Living Situation

☐ Biological parents (married or cohabitating)
☐ Biological parents (divorced/separated) ☐ with visitation ☐ without visitation
☐ Biological mother and stepfather/parent partner ☐ with visitation ☐ without visitation
☐ Biological father and stepmother/parent partner ☐ with visitation ☐ without visitation
☐ Foster or adoptive family
☐ Other: ______________________

Name of mother: ____________ DOB: ________ Employer: ________ Position: ________
Name of father: ____________ DOB: ________ Employer: ________ Position: ________
Date of marriage: ____________ Date of divorce (if applicable): ____________
Mother's highest education level: ____________ Father's highest education level: ____________
Name of stepmother: ____________ DOB: ________ Occupation: ____________
Name of stepfather: ____________ DOB: ________ Occupation: ____________

Names of siblings	Living in the home	DOB	Quality of Relationship
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor
____________	Y N	________	☐ Good ☐ Fair ☐ Poor

Names of stepsiblings		DOB	Quality of Relationship	From mother's marriage (check)	From father's marriage (check)
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐
____________	Y N	________	☐ Good ☐ Fair ☐ Poor	☐	☐

Others living in household:	DOB	Quality of Relationship
____________	________	☐ Good ☐ Fair ☐ Poor
____________	________	☐ Good ☐ Fair ☐ Poor
____________	________	☐ Good ☐ Fair ☐ Poor

Other important persons in the child's life:

Name	Age	Nature of Relationship to Child	Quality of Relationship
____________	____	____________	☐ Good ☐ Fair ☐ Poor
____________	____	____________	☐ Good ☐ Fair ☐ Poor

_____ _____ _____ ☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY QUESTIONS

Does anyone on either the mothers side or fathers side of the family have had or are suspected to have had difficulties with any of the following: (please check those which apply and on which side of family)

		Mother's Side	Father's Side
Attention	Who:	_____	_____
Learning Difficulties	Who:	_____	_____
School Problems	Who:	_____	_____
Behavior Problems	Who:	_____	_____
Depression	Who:	_____	_____
Anxiety	Who:	_____	_____
PTSD	Who:	_____	_____
Drug/Alcohol abuse	Who:	_____	_____
Legal issue	Who:	_____	_____
Hallucinations/delusions	Who:	_____	_____
Bipolar/depression	Who:	_____	_____
Eating	Who:	_____	_____
Epilepsy	Who:	_____	_____
Mental Retardation	Who:	_____	_____
Dementia, Alzheimer's	Who:	_____	_____
Traumatic Brain Injury	Who:	_____	_____
Autism, Aspergers	Who:	_____	_____
Heart or lung problems	Who:	_____	_____
Speech/Language problems	Who:	_____	_____
Genetic Disorders	Who:	_____	_____

Significant Trauma (include age at time of incident, nature of trauma, and any legal details)

☐ Injured in an accident: _____

☐ Physical abuse (child was the ☐ victim ☐ perpetrator): _____

☐ Sexual assault/abuse (child was the ☐ victim ☐ perpetrator): _____

☐ Emotional abuse (child was the ☐ victim ☐ perpetrator): _____

☐ Neglect: _____

☐ Removed from home ☐ Foster care ☐ Residential Treatment ☐ Parent or other removed from home

SOCIAL RELATIONSHIPS

What words best describe the child?

☐ Friendly	☐ Withdrawn	☐ Shy
☐ Popular	☐ Socially awkward	☐ Few friends
☐ Leader	☐ Socially "clueless"	☐ No friends
☐ Used to have more friends	☐ Interested in friends	☐ Not interested in friends

How did the child adjust to the social demands of preschool/kindergarten (e.g., group activities, sharing, playing with other children, etc.)**?** _____

Losses/separations (deaths, moves, etc.): _____

Extracurricular activities/religious participation: _____

DISCIPLINE

Physical: ☐ Spanking ☐ Other: _____

Non-physical: ☐ Time outs ☐ Yelling/screaming ☐ Taking things away ☐ Praise

☐ Other: _____

Child's response to discipline: _____

PERSONAL INFORMATION
What are the child's greatest strengths/attributes? _____
_____

Hobbies/Interests

Recent change in frequency?

_____ ☐ No change ☐ Decreased ☐ Increased
_____ ☐ No change ☐ Decreased ☐ Increased
_____ ☐ No change ☐ Decreased ☐ Increased

LEGAL
Please detail any contacts the child has had with the courts, police, etc.: _____
_____
_____

EMPLOYMENT ☐ No employment history due to age
Was the child ever employed? ☐ Yes ☐ No
Was the child successful at job? ☐ Yes ☐ No – details: _____
Was the child ever fired? ☐ No ☐ Yes – details: _____
Jobs held: _____
Household chores: _____

ACADEMIC
Current school: _____ **Current grade:** _____
Started school at age: _____
Participated in: ☐ Title I reading ☐ Developmental kindergarten ☐ Early childhood education ☐ Birth to 3

Has the child utilized Special Education support services? ☐ No ☐ Yes ☐ IEP ☐ 504 Plan
Please specify below all classifications that have been used, and *circle any current classification*.
☐ Cognitively impaired ☐ Emotionally impaired ☐ Hearing impaired ☐ Visually impaired
☐ Other health impairment ☐ Severe multiple impairment ☐ Speech and language impairment
☐ Learning disabled: _____
☐ Physical disability: _____

Academic Performance:
☐ Consistently above average (A's, B's) ☐ Consistently average (B's, C's)
☐ Consistently below average (C's, D's) ☐ Consistently below average to failing (C's, D's)
☐ Previously strong grades, recent deterioration ☐ Previously weak grades, recent improvement
☐ Dropped out of school (at age: _____, grade: _____)
☐ Graduated from high school ☐ Obtained GED ☐ Regular diploma ☐ Special education certificate

Was child ever:
☐ Held back – What grades? _____
☐ Suspended – For what and for how long? _____
☐ Expelled – From what grade and why? _____
☐ Home schooled – When and why? _____

Additional information you would like to let the clinician know:
_____
_____
_____
_____

Completed by
Parent/Guardian: _____ **Date:** _____

Therapist: _____ **Date:** _____