CHILD INTAKE QUESTIONNAIRE

Confidential and Privileged Information

Please complete the following form to help us understand your child. This will decrease the time needed to make an accurate evaluation of your child's needs. Please print or type information.

Identifying Information

From Completed By: _________________________ Date:___________________

Child's Name: _______________________________Gender: Male Female

Current Age: _____ Date of Birth: _____________________ Grade: _____________

Race/Ethnicity: ____

Pediatrician: ______________________________

Family Information

Mother's Name _______________________________________ Birth date _____________

Highest school grade completed by mother ______________________

Mother's occupation/place of employment ______________________________________

Father's Name ____ Birth date _________

Highest school grade completed by father ________________________

Father's occupation/place of employment _______________________________________

Is your child adopted? ______ No ______ Yes If yes, for how long and any information known about biological parents?:

____

____

____

Are parents married? ______ Yes ______ No If yes, when? _______________________

Are parents separated? ______ Yes _____ No If yes, when? ______________________

Are parents divorced? ______ Yes ______ No If yes, when? ______________________

Are there step-parent(s) involved? ________ Yes ______ No

If yes, when was the remarriage for either parent? ______________________________________

Step-Parent(s) or Legal Guardian(s) Names:______________________________________

Is there any important information about the parents' relationship which might be helpful to know?

____

____

List all siblings (full, half, step, living or deceased) Name; Age; Sex; Relationship to child; Grade; Living with Child?

1. ____

2. ____

3. ____

4. ____

Please give the name and relationship of anyone else currently living in the home

____

History of Current Problem

What are your current concerns regarding your child?

____

____

____

At what age was the problem first noted? ___________

Please describe any illness or injury that may have been associated with the problem.

____

____

Has your child ever had treatment for this problem? ________________

If so, Where? _____________________________ When? __________________

Has your child ever had counseling or psychological services for any other problem? Yes No

If yes, when and where? ____

____

Have there been any significant changes, events, or losses in your child's life?

____

____

____

____

Please circle any of the following areas of concern, past or present:

Anger Management	Poor Concentration	Nightmares
School Problems	Sleeping Problems	Separation Anxiety
Problems Completing Work	Excessive Worry	Hyperactivity
Obsessions/Compulsions	Depressed Mood	Sexual Abuse
Body Image	Lying	Bedwetting/Soiling
Physical Complaints/Pain	Suicidal Thoughts	Self-Injurious Behavior
Family Problems	Hallucinations/Delusions	Aggression
Motor/Vocal Tics	Bullying/Teasing	Medical Issues
Low Self-Esteem	Opposition	Helplessness
Food Issues	Distractibility	Shyness
Irritability	Cruelty to Animals	Impulse Control Problems

Birth, Developmental, & Medical History of Child

Birth History: Did mother use any of the following during pregnancy?

Tobacco	Alcohol	Drugs
_____ Yes	_____ Yes	_____ Yes
______ No	_____ No	______ No

Describe any complications during pregnancy
____
____

Length of pregnancy: ______ Full Term _____ Premature (at _____ weeks)_____ Late
Type of delivery ________________________ Birth weight_________________________
Describe any complications during delivery
____
____
Were there any medical problems noted at or immediately following birth?
____
____
____
Developmental History of Child: Please note the age at which your child reached the following developmental milestones. If unsure of the exact age, give the approximate age.
Sat alone _________ Walked alone _________ Potty Trained _____________
Started using single words (other than “mama” or “dada”) _______
Used 3 word-sentences ________________
Infancy or Toddler concerns?____
____
Developmental Concerns? ____
____

If you are bringing your teenager (12 and over) to the office, does your child have any problems with alcohol or drugs?

Tobacco	Alcohol	Drugs
______ Yes	______ Yes	______ Yes
______ No	______ No	______ No
______ Unsure	______ Unsure	______ Unsure

Medical History of Child: Describe any serious accident, illness, or injury which your child has experienced and what age:
____
____
____
Please list any operations your child has undergone and when:
____
____
Please list any allergies that your child has:
____

List any medications your child is currently taking (name of medication and dosage):
____
____

Please list any significant medical problems of anyone in the family.

____
____

Please list any family mental health history (Include immediate and extended family members).

____
____
____

Educational History of the Child/Teen

Attended Daycare? _____ (*Circle one)* In home daycare Daycare facility At home
Attended Pre-school? ____ Yes____ No Attended Kindergarten?____ Yes ______ No
In gifted program? _____ Yes_____No If yes, describe: __________________________
Receive special education or additional support? _______ Yes ________ No
Does your child have an Individualized Education Plan (IEP) ______Yes _______ No
If yes, why does your child have an IEP? ____
____
Ever had psychoeducational testing? _______ Ever repeated a grade? ________
Ever been suspended or expelled?_______ If yes, what grade and why?______________
____
Current School: ____ Grade: _____________
Type of School: ______ Public _____Private _____Home Schooled
What grades does your child receive? ____
Any recent changes in grades? ____
Feelings about school work (circle all that apply):

Anxious	Passive	Enthusiastic	Tedious
Fearful	Bored	Rebellious	

Other: ____

Approach to school work (circle all that apply):

Organized	Industrious	Responsible	Interested
Self-directed	No Initiative	Refuses	Does only what is expected
Sloppy	Disorganized	Cooperative	Does not complete work

Other: ____

Strengths & Assets of the Child & Family:

What are your child's strengths?

____
____

What are your family's strengths?
____
____

What are your family's favorite activities?
____

What does your child do with unstructured time?
____

Please use the space below to note anything else you feel the psychologist should know in helping your child. Feel free to add your own page if needed.
____
____
____
____
____
____
____