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CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Person Completing Form: _____ Relationship to Client: _____

Demographic Information

Child's Name:_____ Date of Birth:_____ Age:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Family Information

Mother's Name: _____

Address: _____

Occupation: _____ Employer: _____

Home Phone: _____ Is it okay to leave a message at this number? Yes____ No____

Cellular Phone: _____ Is it okay to leave a message at this number? Yes____ No____

Parent's Relationship Status: ☐ married ☐ divorced ☐ separated ☐ widowed ☐ other: _____

Who has legal custody of the child: ☐ both parents ☐ mother ☐ father ☐ other: _____

Father's Name: _____

Address (if different than above): _____

Occupation: _____ Employer: _____

Home Phone: _____ Is it okay to leave a message at this number? Yes____ No____

Cellular Phone: _____ Is it okay to leave a message at this number? Yes____ No____

Please list **all those living in your home** besides the child (including self, spouse, siblings, friends and relatives).

Name	Age	Gender	Relationship to Child
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

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Child/Family History

Please indicate any that your child has experienced:

____ Abuse (please circle: emotional, physical, sexual, verbal)
____ Alcohol or drug abuse by a family member
____ Car accident
____ Conflict between parents
____ Divorce
____ Domestic violence
____ Exposure to a traumatic event
____ Financial stress in the family
____ Health related issues
____ Losses/separations
____ Neglect
____ Other: _____

Please check below if there is a family history of any of the following:

____ Arrests
____ Developmental Delays
____ Emotional/Mental Heath Issues
____ Substance Abuse/Addiction
____ Suicidal Thoughts/Attempts
____ Other: _____

Education Information

School: _____ Grade:_____

Academic Performance: ☐ Above average (A's, B's) ☐ Average or better (B's, C's) ☐ Average or below average (C's, D's) ☐ Below average to failing (D's, F's) ☐ Previous strong grades, recent deterioration ☐ Dropped out of school at age _____
Has your child ever repeated a grade? ☐ No ☐ Yes Please indicate what grade: _____
Has your child ever skipped school or classes? ☐ No ☐ Yes
Has your child ever been suspended from school? ☐ No ☐ Yes
Has your child been expelled from school? ☐ No ☐ Yes
Does your child have a 504 plan? ☐ No ☐ Yes
Does your child have an individualized education plan (IEP)? ☐ No ☐ Yes

Medical and Psychiatric Information

Pediatrician/Doctor:_____ Phone Number: _____

Does your child have any current or past medical concerns? ☐ No ☐ Yes If yes, describe_____
Does your child have any allergies ☐ No ☐ Yes If yes, what?_____

Has your child previously received counseling? ☐ No ☐ Yes If yes, approximate date(s): _____
Has your child been diagnosed with a mental health condition? ☐ No ☐ Yes If yes, diagnosis? _____
Has your child been under the care of a psychiatrist? ☐ No ☐ Yes If yes, approximate date(s):_____
Has your child had a psychiatric hospitalization? ☐ No ☐ Yes If yes, approximate date(s):_____
Has your child received substance abuse treatment? ☐ No ☐ Yes If yes, approximate date(s):_____
Is your child prescribed any medications? ☐ No ☐Yes If yes, please complete below

Name of Medication	Dose	Frequency	Prescribing Doctor

BEHAVIOR CHECKLIST: Please check items that describe your child's behavior over the **past year:**	
□ Academic problems/homework difficulties	□ Mood changes quickly
□ Angry	□ Panic attacks
□ Anxiety	□ Paying attention; focusing difficulties
□ Arguing	□ Perfectionism
□ Being bullied or bullying others (please circle)	□ Repetitive habits
□ Blames others	□ Rigid routines
□ Bossy	□ Unusual behavior
□ Crying frequently	□ Self injury
□ Defiant (to parents or other adults)	□ Separation anxiety
□ Destroys things	□ Sexualized behavior (that seems inappropriate)
□ Dishonest	□ Sexual orientation worries or gender identity concerns
□ Disorganized, loses things	□ Shyness (excessive)
□ Doesn't want to try new things	□ Sleeping, waking difficulties
□ Drug or alcohol use	□ Social anxiety/discomfort in social situations
□ Eating issues (please indicate: too much, too little)	□ Somatic complaints (i.e., frequent headaches/stomachaches)
□ Easily frustrated	□ Stealing
□ Emotional outbursts	□ Strong feelings of guilt or shame
□ Fears	□ Suicide attempts
□ Forgetful	□ Suicidal thoughts (says wants to die)
□ Frequent conflict with parent(s)/guardian(s)	□ Talking back
□ Frequent conflict with sibling(s)	□ Tantrums
□ Hair pulling	□ Threats or comments about wanting to hurt self
□ Hard to make/keep friends	□ Threats or comments about wanting to hurt others
□ Hears or sees things others do not	□ Too concerned with neatness
□ Hits others	□ Transitions are difficult
□ Hurts animals	□ Strong reactions to textures, light, sound
□ Hyper; trouble sitting still	□ Unhappy, sad or depressed
□ Impulsive	□ Unusual thoughts
□ Irritable	□ Wetting/ soiling pants or bed
□ Lack of confidence/low self esteem	□ Withdrawn; isolates
□ Learning difficulties	□ Worries a lot

The 3 things that concern me the <u>MOST</u> are:

1._____

2._____

3._____

Financial Information

☐ Private Pay ☐ Employee Assistance Program ☐ Insurance (please complete below)

Insurance Carrier:_____ Policy #:_____ Group#:_____

Primary Policy Holder's Name:_____ Relationship to Client:_____

Primary Policy Holder's Address: _____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Social Security #:_____

Emergency Contact Information

Person to Notify in Case of an Emergency: _____

Emergency Contact Phone: _____ Child's Relationship to Contact: _____

Additional Information

Please feel free to share any additional information in the space below.

I hereby authorize payment directly to Lauren Morton, LCSW of insurance benefits if applicable. In case of an emergency, Lauren Morton is permitted to communicate with the above emergency contact.

Signature of Parent/Guardian:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____