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Child Intake Questionnaire - *For clients 18 years of age or younger*
Background Information

1. Child/Adolescent's preferred name/nickname to be called: _____

2. Gender Identity (circle): Male Female Other

3. Who should be called regarding scheduling and messages for child? _____

4. Is it OK to leave voice messages on any of the following numbers? (Please check all that apply and provide the preferred phone numbers):

   a. __ Home #: _____

   b. __ Work #: _____

   c. __ Cell #: _____

   d. __ Other #: _____

5. Parental Relationship Status (circle all that apply): never married, partnered, dating, married, separated, divorced, living-together, widowed, other: _____

   Answer **any** that apply to you/your child's family:
   How long have you been in a relationship: _____

   When did you meet: _____

   When did you marry: _____

   When did you separate/divorce: _____

   IF divorced or separated from child(s) parent, please describe current relationship with the other parent: _____

   _____

6. Ethnic/Cultural Identity of Child:_____

   What generation American is your child (i.e.: what generation was born in the USA)?: _____

   What, if any, role does ethnic/cultural identity play in your life: _____

   _____

   _____

7. Religious/Spiritual Family Preference(s):_____

What, if any, role does your religious/spiritual preference(s) identity play in your life: _____

_____

8. Primary Language Spoken in the Home: _____

9. Primary Language Spoken by Client: _____

10. Why are you seeking psychotherapy for your child at this time? _____

_____

_____

11. How would you currently rate your child's problem(s) that you are seeking help with at this time? (On a scale from 1-10 with 1=mild and 10=severe)_____

12. How long has the current problem(s) been occurring? _____

13. How is this problem impacting other members of the family? _____

_____

14. How is this problem impacting your current relationship as parents and/or partners? _____

_____

15. Please list your child's current coping strategies in dealing with the problem(s):_____

_____

16. Please list your family's current coping strategies in dealing with the problem(s):_____

_____

17. Please list what you have tried to address, change or solve the problem(s) your child is struggling with: _____

_____

18. Please list your family's current support systems (e.g.: family, friends, co-workers, faith, community, pets, coach, teacher, etc.): _____

In what ways are you receiving support from the aforementioned? _____

_____

19. Please list any recent life changes or transitions for your family and/or your child (e.g.: births, deaths, job loss/change, move, relationship status, school, friendships, finances, health, etc.):_____

_____

20. What are your child's strengths? _____

_____

21. Is your child currently receiving other services to address the problem (counseling, physical therapy, occupational therapy, services at school, etc)? **Yes** **No** (circle one)
If yes, what services, where and how often? _____

22. Has your child ever received therapeutic services before? **Yes** **No** (circle one)
If yes, for what purpose? _____

What services were helpful and why? _____

_____

What services were not helpful and why? _____

_____

Mental Health Information

1. What, if any, mental health diagnoses do you have or have you had in the past (e.g.: bi-polar disorder, depression, panic disorder, ADHD, OCD, etc.)? _____

2. Is your child currently experiencing or has ever experienced suicidal thoughts? **Yes** **No** (circle one)
If yes, please explain: _____

_____

3. Has your child ever intentionally inflicted harm on him/herself or someone else? **Yes** **No** (circle one)
If yes, please explain: _____

_____

4. Has your child ever been hospitalized for mental health issues? **Yes** **No** (circle one)
If yes, please provide when, where and reason: _____

_____

_____

5. Is your child currently seen by a mental health professional? **Yes** **No** (circle one)
If yes, please provide name/address/phone # of psychiatrist: _____

_____

6. Does your child currently take any medication? **Yes** **No** (circle one)
If yes, please list medication with dosage: _____

_____

7. Does your child currently have a formal Mental Health diagnosis? **Yes** **No** (circle one)
If yes, what diagnosis: _____

Who was the diagnosing practitioner? _____

Developmental/Medical Health

1. Please describe any developmental history or concerns you have or had with your child (pregnancy, milestones, motor skills, speech and language): _____

   _____

2. Does your child have any major illnesses or long-term medical problems? **Yes** **No** (circle one)
   Please explain: _____

3. Does your child require assistance in daily living activities (i.e. getting dressed, eating, toileting, walking, etc)?
   Yes **No** (circle one)
   If yes, please explain: _____

   _____

4. Does your child have any difficulties with sleep? **Yes** **No** (circle one)
   If yes, please explain: _____

   _____

5. Does your child have any issues related to eating? **Yes** **No** (circle one)
   If yes, please explain: _____

   _____

6. Does your child have consistent weekly activity? **Yes** **No** (circle one)
   If yes, please explain: _____

7. Who is your child's physician (please provide name/address/phone #)? _____

   _____

Social History

1. Does your child attend school? **Yes** **No** (circle one)
   If yes, please provide school name, address, phone #: _____

   _____

   What grade is your child in? _____

   Is your child in a full-time regular classroom? _____

   Does your child receive supportive services from school? **Yes** **No** (circle one)
   If yes, what services and how often? _____

   _____

2. Does your child have any learning issues or disabilities? **Yes** **No** (circle one)
   If yes, please describe: _____

   _____

3. Does your child have any issues related to socialization (i.e. difficulty making/maintaining friends, lack of significant peer group, exhibit anti-social behaviors)? **Yes** **No** (circle one)
If yes, please describe: _____

_____

4. Please list your child's participation in extra-curricular activities: _____

_____

5. Please list your child's hobbies or areas of interest: _____

_____

6. Pleas list all of your child's volunteer positions or jobs (i.e. babysitting, dog walking, paper route, etc)?
_____

Substance Use

1. Does your child smoke cigarettes? **Yes** **No** (circle one)

2. Does your child drink alcohol or take any recreational drugs? **Yes** **No** (circle one)

If yes, please describe: _____

3. Do you have any concerns related to your child and substance abuse? **Yes** **No** (circle one)
If yes, please explain: _____

_____

4. Does anyone in your child's family currently have or has had in the past a substance abuse problem?
Yes **No** (circle one)
If yes, please describe: _____

_____

Family Background

1. Please list current members of your family:

Name & Relationship to Child	Age or Date of Birth	Occupation or Year in School	Currently living with Client? (yes or no)

2. Please list any information about your child's family and relationships (i.e. divorce, extended family, past abuse experienced or witnessed by child, etc.): _____

_____

3. Have any family members experienced and/or been diagnosed with a Mental Health Disorder?
Yes **No** (circle one)
If yes, please explain: _____

4. Have any family members experienced and/or been diagnosed with any learning issues or disabilities?
Yes **No** (circle one)
If yes, please explain: _____

Legal Concerns

1. Is your child or any immediate family members currently involved in any court case? **Yes** **No** (circle one)
If yes, please describe: _____

_____

7. Are you currently involved in divorce mediation or a custody case? **Yes** **No** (circle one)
If yes, please describe: _____

_____

3. Is there currently a custody agreement in place? **Yes** **No** (circle one)
If yes, please describe agreement (please note: the Studio For Change needs a copy of the custody agreement for your child's file): _____

_____

What are your main goals for your child and/or your family in therapy?

1._____

2._____

3._____

Please list anything else you would like me to know about you, your child and/or your family before you initiate therapy:

_____

_____

_____

_____

_____