Patient Questionnaire/Intake - Child

General:

Client Name ____ Date __________________
Parent/Guardian Name ____
Address _________________________________ Home phone__________________________
Cell phone ____________________________ Fax _______________________________
E-mail ______________________________ Referred by __________________________
Client Age ____________________________ Date of birth _________________________
Parental Marital status ____________________ Educational level _______________________
Parent(s) Occupation ____________________ Names and ages of other children __________
____
____
Emergency contact information (name and phone number)_____________________________
____
Explanation of how patient/parent may be contacted by therapist ___________________________
____

Parent/Guardian Financial Information:

Annual household income ________________ Do you own or rent? __________________
How do you intend to pay for treatment? (cash, check, charge, insurance) _____________________
If planning to use health insurance: Therapist is not currently accepting insurance but therapist will provide a bill for client to seek reimbursement on their own.
Name of insurance company ____N/A________________ Policy number ___________N/A______
Group number _____N/A_____ Telephone number _________N/A______

Areas of Concern:

What issues/concerns causes you to seek treatment for your child? Please describe. _______________
____
____
____
____
____
____
____
Do you have any specific goals with regard to your child's treatment? _________________________
____
____
____
Do you or your child have any particular concerns/fears with regard to treatment? _______________
____
____
____

Psychological History:

Have you or your child ever received mental health treatment before? ________________________
When and for how long? ____
____
____
What was the focus of treatment? ____
Name of treating therapist(s), address(es), telephone number(s) ______________________________
____
____
*Authorization for release of confidential information will be needed so that any former therapist may be contacted.

Have you or your child ever taken one or more psychological tests? _________________________
____ If so, by whom?

Name of person(s) administered psychological tests, address(es), telephone number(s)
____
____
*Authorization for release of confidential information will be needed so that any test administrator may be contacted.

Have you or your child ever been hospitalized for mental or emotional problems? _______________
When and for how long? ____
____
____
Why were you or your child hospitalized? ____
____
____
____
Name of treating therapist, address, telephone number ____________________________________
*Authorization for release of confidential information will be needed so that any former therapists may be contacted.

Is your child currently taking any prescription medications? __________________________________
Prescribed by whom? ____
How long have they been on the medications? ____
Has your child ever taken any medications for a mental or emotional condition? ______________
When and for how long? ____
*Authorization for release of confidential information will be needed so that health care provider may be contacted.

Does your child currently self-harm?___________ If so, how often_______________________
Has your child ever accidentally cut to deep or hurt themselves more than they intended?__
____
Did your child previously self-harm?_____________ What helped them stop?_____________
____
Has your child ever attempted suicide? ____
When? ____
Describe the circumstances that led to that attempt. _______________________________________
____

Is your child currently having any suicidal thoughts? Please describe ___________________________

Please describe your child's childhood so far.____

Was your child ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

Has your child ever been a victim of a violent crime? Please describe _________________________

Medical History:

Has your child ever been diagnosed with a serious illness? Please describe _____________________

Does your child have any medical conditions that may affect your mental health treatment? ________
Please describe your child's overall health today. ____

Is your child experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. ____

Has your child ever been in a 12-step program? Please describe.______________________________

Does your child smoke/drink/ use substances? __________________ How much? ______________
For how long?____
Has your child ever tried to cut back? ___________ What happened?_______________________
Does your child currently use smoke or use substances? _____________________________________
Please describe your child's use ____

Have you ever used drugs? Please describe. ____

Family of Origin History:

Mother's name, age, living/deceased, patient's age at the time of mother's death(if applicable), health issues, mental health issues, description of own relationship with parents, description of child's relationship with mother.____

Father’s name, age, living/deceased, patient’s age at the time of father’s death(if applicable), health issues, mental health issues, description of own relationship with parents, description of child’s relationship with father. ____

Names and ages of siblings. ____

Other Information:

Please tell me a little about your child (i.e. spiritual beliefs, ethnic identification, sexual orientation, relationship status, values/beliefs). ______________________________________

Please describe your child’s interests/hobbies ____

Is your family involved in a lawsuit now or have you ever been? ___________________________
Please describe. ____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. ____