Child Intake Questionnaire

Name: _____ Preferred Name:_____ Date of birth:_____
Current Address:_____
Street apt # City Zip Code Phone Number

I am seeking counseling services for my child because:_____
_____
When did it start? How often does it happen? How does this problem affect life?_____
_____

Parents are: _____
Father Mother
(Please circle) Still together Divorced One of both deceased Other:_____

Child has seen other counselors:_____yes (who/where) _____no
Child has taken medication for mental health challenges:_____ yes (what) _____no
Child has been seen at Community Mental Health (CMH): _____yes (where) _____no
Trauma (head injury, childhood abuse, domestic violence) in child's past?_____yes _____no
List them briefly:_____

Mental illness or substance abuse in the family? _____yes _____no
Who / what:_____

Do they have any medical conditions? _____yes _____no
_____
_____

List current medications. Dosage, how often do they take it and the prescriber for each medication.
_____
_____
_____
Has your child ever overdosed on a medication? _____yes _____no
If yes, what were the circumstances?_____
_____
Supplements:_____
_____

How do they sleep? _____
How's the health of their diet?_____
Are they physically active on a regular basis?_____

Are you aware of any delays in their childhood development? _____yes _____no
(Walking, talking, potty training, socializing, delivery complications, other) _____

Current grade and school my child attends:_____
Were they ever in Special Education (for what subject) or held back a grade?_____
_____

My child has _____ siblings and their names and ages are:_____
_____
_____

Please list all other individuals you consider to be a part of your family and what is your child's relationship is like with them:_____
_____

What is life like for your child as they are growing up, at home?_____
_____
What is life like in school?_____
_____

What are their friends like?_____
_____

Are they involved in any volunteer or social groups? _____yes _____no
If yes please list: _____

For relaxation or for fun my child enjoys:_____
_____

Please list any current legal or Child Protective Services history (custody issues, probation, civil, criminal, PPO's in the family, jail of family members, etc):_____
_____

Have you noticed any recent changes in your child's:

Sleeping Patterns	_____yes	_____no	Behavior	_____yes	_____no
Eating Patterns	_____yes	_____no	Energy	_____yes	_____no
Physical Activity	_____yes	_____no	Weight	_____yes	_____no
Increased tension/ nervousness	_____yes	_____no	Disposition	_____yes	_____no

If yes to any of the above, describe:
_____
_____
_____
_____

What strengths and abilities are you or your child bringing to sessions:_____
_____

What needs or preferences do you have that will help us be successful?_____
_____

What else is important to know that will help make our time more effective?_____
_____

_____
Signature of Parent / Guardian Date