Child Intake Questionnaire

Child's Name: _____Date of birth: _____

Current address: _____
Street apt # City Zip Code

I am seeking counseling services for my child at this time because:_____

_____

Parents are: _____ _____
Father Mother

(Please circle) Still together Divorced One or both deceased Other: _____

The child has (how many) _____ siblings and _____ step-siblings, and their names and ages are:

_____ _____ _____

_____ _____ _____

Current grade and school my child attends: _____

Child ever enrolled in special education classes? _____ yes _____ no If yes, for _____

My child has seen other counselors . _____ yes _____no

If yes, who did you see.

Who When

1) _____ _____

2) _____ _____

Trauma (head injury, childhood abuse, domestic violence) in child's past? _____yes _____no

If yes, explain:_____

Mental illness in child's family? _____yes _____no

Who and what condition? _____

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

If yes, what delays/complications:

_____

Does your child have any present or past medical conditions? (If yes, please list below) _____yes _____no

_____ _____

List current medications and who prescribes them. Their doctor is: _____

_____ _____

Has your child ever overdosed on a drug or medication? _____yes _____no

If yes, what were the circumstance:_____.

Is your child involved in any extracurricular or social groups? If yes please list below. _____yes _____no

_____ _____

Please list any current legal or Child Protective Service history (custody, probation, civil, criminal):

_____ _____

_____ _____

Relationships

Please briefly describe how your child gets along with:

Parents:_____

Siblings:_____

Other Children:_____

Teachers:_____

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: _____

_____

For fun, my child enjoys:_____

_____ _____

Signature Date