CHILD & ADOLESCENT
INTAKE QUESTIONNAIRE

Confidential

The following questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information which you think may be helpful in understanding your child. Household information provided by you is strictly confidential and will only be released in accordance with HIPPA guidelines and as mandated by law. Please use the backs of the pages for additional information.

PLEASE PRINT

Name of Person Completing this form: _____

Legal Name of Child/Adolescent: _____

Nickname or name child routinely goes by: _____

Child's Date of Birth: _____ Age: _____

Home Address: _____
Street

_____ _____ ____ _____
City County State Zip

Home Telephone Number: ____-____-_____ Work Phone(s) Mother: ____-____-_____
Father: ____-____-_____

Cellular Phone(s) Mother: ____-____-_____
Father: ____-____-_____ Preferred Email: _____

School Name: _____ System:_____ Grade: _____

School Telephone Number: _____ Contact Person: _____

Current Teacher(s): _____

_____

Who referred you to our office? _____

Please describe the problems your child is now having, and what type of services you are seeking from us for these problems. Please use the back of this page for additional space.

_____

_____

_____

INDICATE PARENTS/GUARDIANS LIVING IN THE HOME:

Marital Status: Married Remarried Divorced Separated Widowed Single Cohabitants

- If divorced, who has physical custody? _____ Is it full or joint? _____
- Who has legal custody? _____ Is it full or joint? _____
- If divorced, please provide a copy of the custody agreement.

Mother's Name_____
Date of Birth: _____ Age: _____
Occupation: _____
Employer: _____
Education Completed_____ Health: _____Excellent _____Good _____Fair _____Poor

Father's Name_____
Date of Birth: _____ Age: _____
Occupation: _____
Employer: _____
Education Completed_____ Health: _____Excellent _____Good _____Fair _____Poor

Does either parent's job require him/her to be away from home long hours or extended periods?
_____

If married, how long have you been married? _____

If divorced, how long have the biological parents been divorced? _____

Has either parent been married before or since? Mother:_____ Father:_____

Please list the name(s) of the stepparents:_____

If yes, provide dates of previous marriage(s), names, and ages of children from these marriages:

Mother:_____ Children & Ages:_____

Father:_____ Children & Ages:_____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER
Name:_____ Where do they live?_____

If birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?

_____
_____
_____
_____
_____
_____

_____
_____

Siblings:

	Name	Age	Relationship	Living in Home?	School	Grade
1.	_____	_____	_____	Y/N	_____	_____
2.	_____	_____	_____	Y/N	_____	_____
3.	_____	_____	_____	Y/N	_____	_____
4.	_____	_____	_____	Y/N	_____	_____

- Please list additional Siblings in the above format on the back of this page.

Please indicate any special needs of concerns regarding the other children living in your home:

_____

_____

_____

_____

Please indicate any concerns you have regarding the child for whom you are seeking services and these siblings relationship(s):

_____

_____

_____

_____

Others: List any other people who currently, or in the child's lifetime, have lived in your home.

Name	Age	Relationship to Child	Years Living in Home
1. _____	____	_____	From_____ To_____
2. _____	____	_____	From_____ To_____
3. _____	____	_____	From_____ To_____
4. _____	____	_____	From_____ To_____
5. _____	____	_____	From_____ To_____

Are there any other people who have a significant role on how this child is raised? _____

_____

_____

_____

PSYCHOLOGICAL HISTORY:

Is there a history in your immediate or in the mother's or father's extended family, of the following, and if so who?

Yes	No		Who
___	___	Autism Spectrum Disorders	_____
___	___	Learning Problem/Disabilities	_____
___	___	ADHD – ADD- Attention Problems	_____
___	___	Depression & Manic-Depression	_____
___	___	Behavior Problems in School	_____
___	___	Anxiety Disorders (OCD, Phobias, etc.)	_____
___	___	Mental Retardation	_____
___	___	Psychosis/Schizophrenia	_____
___	___	Substance Abuse/Dependence	_____
___	___	Other Mental Health Concern (Please List)	_____

Has the child you are seeking services for been evaluated in the past? Yes/No

If Yes, please list the following information on the previous evaluation(s):

	Who	Type	When	Copy Available
1.	_____	_____	_____	Y/N
2.	_____	_____	_____	Y/N
3.	_____	_____	_____	Y/N
4.	_____	_____	_____	Y/N

(If more evaluations need to be listed please use the space on the back of this page. □)

If yes, what were their general findings and recommendations? _____

_____

_____

_____

Please provide us with any other information on the psychological history that you feel would be helpful to us in understanding your child: _____

_____

_____

_____

PRE-NATAL AND DELIVERY HISTORY:

- Did the birth mother receive regular pre-natal care? Y/N
- Were there any complications with the Pregnancy? Y/N

If Yes, please provide details: _____

_____

_____

If Yes, please provide treatment details: _____

_____

_____

- Was birth at Full Term? Y/N

If No, please provide details: _____

_____

_____

- Type of Delivery: Spontaneous/Induced Vaginal/C-Section
- Complications? Y/N

If Yes, please provide details: _____

_____

_____

- Birth Weight: ____lbs ____oz Apgar Scores: _____ _____

- Concerns at Birth? Y/N

If Yes, please provide details – including any treatments given (Additional space on back if needed):

_____

_____

_____

Is there any additional pre-natal or birth information that might be of assistance to us?_____

_____

_____

_____

Has your child ever had a fever above **104°**? Yes No

If yes, Please explain:_____

Has your child ever had a seizure of unexplained period of unconsciousness? Yes No

If yes, Please explain:_____

Has your child ever had a head trauma or blow to the head that cause unconsciousness or required a medical review?

If yes, Please explain:_____

(Please use the back of the form as necessary to complete your responses.)

DEVELOPMENTAL HISTORY:

1. Please indicate the age at which your child did the following:

Rolled Over consistently _____

Sat up unsupported _____

Stood _____

Crawled _____

Walked Unassisted _____

Said 1st Word Intelligible to strangers _____

Said two-three word phrases _____

Used Sentences regularly _____

Toilet trained during the day _____

Dry through the night (6+ months) _____

Dressed Self _____

2. Please indicate if your child is experiencing any of the following:

Problems with eating _____

Isolated socially from peers _____

Problems making friends _____

Problems keeping friends _____

Problems getting to sleep _____

Problems controlling temper _____

Problems sleeping through the night _____

Trouble waking up _____

Fatigue/tiredness during the day _____

Nightmares _____

Bed wetting _____

Soiling _____

Problems with authority _____

Anxiety _____

Unmotivated _____

Stress from conflict between parents _____

Legal situation (anyone in the family) _____

History of abuse _____

Alcohol/drug use/abuse _____

School concentration difficulties _____

Grades dropping or consistently low _____

Sadness or Depression _____

3. List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had.

_____

_____

_____

4. List any medications your child is currently taking or has taken for extended periods (give dates and dosage level, if possible): _____

_____

_____

_____

5. Child's current height: _____Ft. _____Inches Weight: _____Lbs.

6. With which hand does the child write? _____

7. Does the child have any vision problems? _____

Please list date of last vision test and who performed (pediatrician, optometrist, school)

_____

_____

8. Does the child have any hearing problems? _____

Please list date of last hearing test and who performed (pediatrician, audiologist, school)

_____

_____

9. Name of child's physician(s) _____

Practice Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

(Please list information on additional Physicians on the back of the page □)

EDUCATIONAL HISTORY:

1. List in chronological order all schools your child has attended:

Name	System	Year(s)	Grade	Special Ed?
•				
•				
•				
•				
•				

2. Name(s) of current teacher(s)_____
3. Does your child's teacher have concerns about him/her (list) _____

_____

4. What is your child's favorite subject/class? _____
5. What is your child's least preferred subject/class?_____
6. Has your child ever repeated a grade? Y/N If yes, what grade(s)?:_____
7. If your child has been in Special Education, did they have a:

☐ 504 Plan ☐ I.E.P.

☐ Psychological Evaluation ☐ Speech Evaluation

☐ Behavior Intervention Plan ☐ Occupational Therapy Evaluation

☐ Physical Therapy Evaluation ☐ Adaptive Technology Evaluation

☐ Other(s): _____

_____

_____

8. If your child has been in Special Education, how were they served?

☐ Consultation ☐ Resource Classroom

☐ Collaborative Education ☐ Team Taught Classes

☐ Pull-Out ☐ Self-Contained Classroom

☐ Special Program ☐ Psychoeducational Center