



INTAKE QUESTIONNAIRE

The information in this packet is confidential and protected under the privacy act of 1974.

To be used with children between the ages of 5 and 18.

INSTRUCTIONS: For children able to understand and write out answers independently: Parents/Guardians will complete part I and the child will complete part II.

For children unable to independently answer the questions: Parents/Guardians will complete part I. The provider will provide guidance regarding the completion of part II which may include leaving it blank or reading the questions aloud to the child and writing in the answers for him/her.

Part I

To be completed by the parent or guardian (Complete **ONE** per family if appropriate)

Date: _____

I. Demographics:

Name of parents/guardians: _____

Who is completing Part I of this form? _____

Address (Street Number and Street Name): _____

City: _____ State: _____ Zip: _____

Phone number: (____) _____ Type: Work Home Cell May we leave a message? Yes No

Alternate phone number: (____) _____ Type: Work Home Cell May we leave a message? Yes No

Email Address: _____ May we email you? Yes No

Please note: Email correspondence is not considered to be a confidential means of communication.

How were you referred to us? _____

II. Parent(s) / Guardian(s) Information

ANSWER THE FOLLOWING QUESTIONS REGARDING THE **MOTHER OR ONE OF THE PARENTS / GUARDIANS**

Name (First, Middle Initial, Last): _____

Gender: Male Female Birth Date: _____ Age: _____ Place of Birth: _____

Education:

	Level	Name of School	Degree	Year Completed
	High School		Diploma / GED	
	College		Associates / Bachelors	
	Graduate School		Masters / Doctoral Level	

Relationship to Child:

- Biological Stepparent Foster / Adoptive Legal Guardian Other:

Check all that apply to the **mother or one of the guardians** currently:

- Never Married Separated Divorced Remarried Widowed
 Dating Married Common Law Domestic partnership

How long have you been in your current committed relationship (married, common law, domestic partnership)? _____

Describe your relationship with your spouse / partner? _____

How many times have you been married? _____

How many children do you have? _____ What are the ages / genders of the children? _____

Describe your relationship with your children? _____

ANSWER THE FOLLOWING QUESTIONS REGARDING THE **FATHER OR THE OTHER PARENT / GUARDIAN**, if applicable

Name (First, Middle Initial, Last): _____

Gender: Male Female Birth Date: _____ Age: _____ Place of Birth: _____

Education:

	Level	Name of School	Degree	Year Completed
<input type="checkbox"/>	High School		Diploma / GED	
<input type="checkbox"/>	College		Associates / Bachelors	
<input type="checkbox"/>	Graduate School		Masters / Doctoral Level	

Relationship to Child:

- Biological Stepparent Foster / Adoptive Legal Guardian Other:

Check all that apply to the **mother or one of the guardians** currently:

- Never Married Separated Divorced Remarried Widowed
 Dating Married Common Law Domestic partnership

How long have you been in your current committed relationship (married, common law, domestic partnership)? _____

Describe your relationship with your spouse / partner? _____

How many times have you been married? _____

How many children do you have? _____ What are the ages / genders of the children? _____

Describe your relationship with your children? _____

III. Family Information / History

List all children in the home

Name	Age	Problems or Diagnoses

List all other people living in the home

Name	Age	Relationship

Current stressors in the family: _____

Continue to the next section and complete ONE for EACH child who will be evaluated in this clinic

I. Child's Information:

Patient's Name (First, Middle Initial, Last): _____

Gender: Male Female Birth Date: _____ Age: _____ Place of Birth: _____

Name of the individual with primary legal rights of the child: _____

Name of the individual with primary custodial rights of the child: _____

What issues/concerns would you like the therapist to address with your child? _____

How long has this issue been a concern? _____

Why seek treatment now? _____

Has your child had difficulties like this before Yes No

If yes, please explain: _____

What are your child's three greatest stressors?

1. _____

2. _____

3. _____

How does your child typically cope with stressors?

Describe the relationship(s) of the child with others in the family / home:

Other current treatment: _____

II. Child's Race / Ethnic Ancestry:

- Asian Black Caucasian / White Hispanic / Latino(a)
 Native American / Alaskan Pacific Islander Other _____

First Language: _____ Second Language: _____

Number of years child has been in an English-speaking home: _____

III. Child's Home Life:

Discipline

What do you use for discipline with this child? _____
Does it work? Yes No
Does it work for other children in home? Yes No
Is there consistency in discipline amongst parents/guardians/caretakers? Yes No
If no, please explain: _____

Free Time

What does the child do in his/her free time: _____
How much time does the child spend:
Watching TV _____ Playing video games _____ On the computer _____
Does the child have a TV of his/her own? _____
What kind of TV shows or movies does the child like? _____
What kind of video / computer games does the child like? _____

IV. Child's Mental Health Treatment History:

Has the patient ever had outpatient treatment or therapy? Yes No
When and by whom: _____
What was the diagnosis? _____

Mental Health Hospitalizations Yes No

Date(s)	Reason	Outcome

Has the patient ever experienced a head injury or traumatic brain injury? Yes No Describe: _____

Is the patient currently taking psychiatric medications? Yes No

Name of Medication	Reason	Dose

Does anyone in the patient's family have mental illness or an emotional difficulty? Yes No

Please specify: _____

Has the patient experienced or witnessed any of the following?

- Physical abuse Sexual abuse Verbal abuse Psychological / Emotional abuse

V. SYMPTOMS / PROBLEMS

Indicate if your child has now or has ever had any problems for each of the following categories:

Behavioral / Emotional

	Past	Now	Never
Nightmares			
Behaves like the opposite sex			
Has to be "perfect"			
Picks at skin			
Bites nails			
Pulls out hair, eyebrows, or eyelashes			
Difficulty paying attention			
Sleeps too much			
Sleeps too little			
Difficulty falling asleep at night			
Difficult to wake up			
Wakes up during night			
Wets self during the day			
Wets the bed at night			
Soils self during the day			
Soils the bed at night			
Washes hands excessively			
Checks things, such as locks, repeatedly			
Uncontrollable impulses			
Complains of a lot of aches and pains			
Unusual / Inappropriate interest in sex			
Sees people or things that are not there			
Hears voices or noises that are not there			
Makes paranoid comments			

	Past	Now	Never
Sadness			
General unhappiness			
Loss of interest in activities			
Nervous or high strung			
Anxiety, fears			
Excessive worry			
Mood swings			
Irritability			
Aggression			
Loss of control when angry			
Inflexibility			
Grief/loss			
Concern about dirt, germs			
Weight gain			
Eating too much			
Weight loss			
Eating too little			
Excessive dieting			
Vomiting			
Using laxatives to control weight			
Weighing daily			
Fear of gaining weight			
Low energy, tiredness			

Academic / Educational

	Past	Now	Never
Sudden drop in grades			
Afraid of going to school			
Refuses to go to school			
Very good at memorizing things such as commercials, songs, nursery rhymes			
Doesn't pretend when playing			

	Past	Now	Never
Learning or academic problems			
Poor concentration			
Hyperactivity, impulsivity			
Tends to line toys or things up neatly			
Tends to play with the same things			

Suicidal Behaviors

	Past	Now	Never
Suicide threats			
Prepares to harm self			
Cuts or burns self			

	Past	Now	Never
Suicide gestures or attempts			
Threatens to harm self			
Researches suicide or death			

Sensory/Motor

	Past	Now	Never
Overly sensitive to odors, sounds, textures			
Seems to be in a world of his/her own			
Problem regulating body temperature			
Repeats certain acts over and over			
Dislikes having hair washed			
Dislikes having face washed			
Prefers certain textures of clothes			
Bothered by tags in clothes			
Overly sensitive to pain			
Sudden, rapid, non-rhythmic movements:			
Blinking			
Head jerking			
Shoulder shrugging			
Touching			
Jumping			
Sudden, recurrent vocalizations:			
Barking			
Grunting			
Snorting			
Sniffing			
Words			
Phrases			

	Past	Now	Never
Putting things in mouth			
Coordination or clumsiness			
Rocking			
Headbanging			
Thumb-sucking			
Tantrums			
Poor eye contact			
Bedwetting after age 5			
Soiling after age 3			
Loss of previous abilities			
Flaps hands or arms when excited			
Sudden laughing			
Frequent throat clearing			
Spinning			
Grinding teeth			
Screaming spells			
Accident prone			
Walking on toes			
Drooling excessively			
Messy when eating			
Resists being touched			
Dislikes being held			
Irritable when held			
Troubles eating or swallowing			

Social / Relational	Past	Now	Never
Speech or language problems			
Clings to adults			
Lonely			
Demands a lot of attention			
Prefers to play alone			
Aggressive with other children			
Always wants to be in charge			
Bullied by others			
Bullying others			
Uses drugs			
Uses alcohol			
Uses tobacco			
Hangs around troubled kids			
Defiant, disrespectful			
Steals			
Swears			
Sets fires			
Runs away			

	Past	Now	Never
Family problems			
Parents arguing frequently			
Parents' pending divorce or separation			
Doesn't fit in with peers			
Lacks interest in others			
Doesn't share interests of other children			
Seen as "different" by other children			
Seems unaware of other children			
Doesn't participate in group activities			
Seems unaware of the needs / feelings of others			
Doesn't seek to share interests or enjoyment with others			
Problems with relationships			
Doesn't play well with other children			
Seems unable to recognize the use for social rules, such as politeness, greetings, farewells			
Sexually inappropriate behavior			

Check next to any of the items below have ever applied to your child:

Communication

- | | |
|---|--|
| <input type="checkbox"/> Talks to self | <input type="checkbox"/> Responds with a lot of giggles or nervous laughter when asked questions |
| <input type="checkbox"/> Talks too much | <input type="checkbox"/> Speaks in long, rambling sentences |
| <input type="checkbox"/> Talks just to talk | <input type="checkbox"/> Talks continually about a certain subject, even if people try to change the subject |
| <input type="checkbox"/> Says bizarre things | <input type="checkbox"/> Does not respond to name |
| <input type="checkbox"/> Says inappropriate things | <input type="checkbox"/> Repeats what others say |
| <input type="checkbox"/> Repeats self | |
| <input type="checkbox"/> Difficulty understanding humor | |

VI. Child's Character Strengths:

Please check any of the following characteristics that you consider your child to have:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Empathy | <input type="checkbox"/> Creativity | <input type="checkbox"/> Curiosity | <input type="checkbox"/> Open-mindedness |
| <input type="checkbox"/> Integrity | <input type="checkbox"/> Vitality | <input type="checkbox"/> Love | <input type="checkbox"/> Kindness |
| <input type="checkbox"/> Leadership | <input type="checkbox"/> Forgiveness / mercy | <input type="checkbox"/> Humility / modesty | <input type="checkbox"/> Prudence |
| <input type="checkbox"/> Gratitude | <input type="checkbox"/> Hope | <input type="checkbox"/> Humor | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Love of learning | <input type="checkbox"/> Perspective / wisdom | <input type="checkbox"/> Bravery | <input type="checkbox"/> Persistence |
| <input type="checkbox"/> Social intelligence | <input type="checkbox"/> Socially responsible / teamwork | <input type="checkbox"/> Fairness | <input type="checkbox"/> Intelligence |
| <input type="checkbox"/> Self-regulation / self-control | <input type="checkbox"/> Appreciation of excellence / beauty | | |

STOP HERE

Please have your child complete the next section if he/she is developmentally capable

Part II

The information in this packet is confidential and protected under the privacy act of 1974.

To be completed by THE PATIENT, if developmentally capable

Patient's Name (First, Middle Initial, Last): _____

Date of Birth: _____

I. Social History:

Who do you normally live with? Check all that apply:

- Biological parents
- Adoptive parents
- Stepparents
- Siblings
- Grandparents
- Relatives
- Others

Overall, how would you describe your life? Check all that apply:

- Happy
- Uneventful
- Unhappy
- Hard to remember
- Frightening
- Other: _____

Are you experiencing any of the following? (*If you are not sure if you are experiencing these types of abuse, please ask your mental health provider.*)

- Physical abuse
- Sexual abuse
- Verbal abuse
- Psychological / Emotional abuse

Does anything happen at home that makes you feel uncomfortable? Yes No

If so, what happens? _____

II. Education:

What grade are you in? _____

What school do you go to? _____

How would you describe your academic performance?

- Excellent (A's and B's)
- Good (B's)
- High average (B's and C's)
- Average (C's)
- Poor (C's, D's, and F's)

Check all that apply to you at school:

- No problems
- Difficulty concentrating
- Difficulty with teachers/staff
- Academic problems
- Behavioral problems
- Learning disabilities

Do you like school? Yes No

Do you participate in sports or band? Yes No

III. Legal History:

Have you ever been in jail/prison? Yes No

Are you currently on probation or parole, or awaiting a pending court case? Yes No

Prior and current charges/arrests (please list reasons and provide dates): _____

IV. Employment History:

Do you have a paying job? Yes No

If yes, describe your job: _____

If no, skip to "V. Leisure/Social Functioning" on the next page

Do you enjoy your work? Yes No
What is stressful about your current job? _____

Check all that applied during your employment. I had problems with:

- No problems With supervisors Difficulty following rules
 With coworkers With customers Difficulty controlling temper

V. Leisure/Social Functioning

Which of these do you enjoy doing in your free time?

- Playing sports Reading Playing on the computer Playing video games Shopping
 Motorcycles/Racing Talking with friends Exercising _____

Are you currently doing these things? Yes No

VI. Substance Use History

Have you ever had alcohol? Yes No

On average, how many days per week do you currently use alcohol? (Please put N/A if you do not drink): _____

On average, how many drinks do you have at a time? (Please put N/A if you do not drink): _____

What is your drink of choice when you drink? (Please put N/A if you do not drink): _____

Have you ever used illicit / illegal drugs or misused prescription medications? Yes No

Do you currently use illicit / illegal drugs or misuse prescription medications? Yes No

What type(s) of drugs do you use? (Please put N/A if you do not use drugs) _____

What is the approximate date of your last use of illicit drugs? (Please put N/A if you do not use drugs) _____

Are you concerned about your current drinking or drug use? Yes No

Have you ever received substance abuse treatment? Yes No

If so, please list where you received treatment, and when this occurred: _____

Do you use tobacco products? Yes No If yes, what type? _____

How much do you use per day? (Please put N/A if you do not use tobacco products) _____

VII. Mental Health History:

Have you ever had outpatient treatment or therapy? Yes No

When were you treated, and by whom: _____

What was the diagnosis? _____

Have you ever been hospitalized in a psychiatric unit or psychiatric hospital? Yes No

When and where: _____

Have you ever experienced a head injury or traumatic brain injury? Yes No Describe: _____

Are you currently taking medications for mood, attention, or other psychiatric condition?

Yes No

Name of Medication	Reason	Dose

Does anyone in your family have mental illness or an emotional difficulty?

Yes No

Please specify: _____

Have you ever intentionally harmed yourself without wanting to kill yourself (e.g., cutting, burning, etc.)?

Yes No

If yes, when was the last time? _____

Are you feeling helpless or hopeless?

Yes No

Do you have CURRENT thoughts of suicide or self-harm?

Yes No

Do you have a specific plan or intent to hurt yourself currently?

Yes No

Have you ever had suicidal thoughts or attempted suicide?

Yes No

If yes, please list the date this occurred, and describe the circumstances: _____

Do you have CURRENT thoughts about homicide or hurting someone else?

Yes No

If yes, do you have a specific plan or intent to harm someone else?

Yes No

VIII. Medical History:

Current medical problems, surgeries, or illnesses and date of onset:

Do you have chronic pain?

Yes No

IX. Current Symptoms / Problems:

Check all that have applied to you in **the past 30 days:**

<input type="checkbox"/> Sad mood <input type="checkbox"/> Loss of interest in activities <input type="checkbox"/> Feelings of guilt <input type="checkbox"/> Low energy, tiredness <input type="checkbox"/> Poor concentration <input type="checkbox"/> Changes in appetite <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Weight gain (____ lbs) <input type="checkbox"/> Weight loss (____ lbs) <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Unable to return to sleep <input type="checkbox"/> Decreased thoughts about sex <input type="checkbox"/> Increased thoughts about sex <input type="checkbox"/> Grief/sense of loss <input type="checkbox"/> Excessive worry <input type="checkbox"/> Rapid mood swings <input type="checkbox"/> Irritability <input type="checkbox"/> Frequent anger outbursts	<input type="checkbox"/> Racing thoughts <input type="checkbox"/> Risky behaviors <input type="checkbox"/> Gambling <input type="checkbox"/> Increased self-esteem <input type="checkbox"/> Decreased need for sleep / staying awake for several days <input type="checkbox"/> Unusual increase in energy / activity <input type="checkbox"/> Trauma <input type="checkbox"/> Avoiding others <input type="checkbox"/> Repeated, unwanted thoughts / images <input type="checkbox"/> Flashbacks: _____ per week / month <input type="checkbox"/> Nightmares: _____ per week / month <input type="checkbox"/> Memory problems <input type="checkbox"/> Panic or anxiety attacks <input type="checkbox"/> Anxiety in social or performance situations <input type="checkbox"/> Uncontrollable impulses <input type="checkbox"/> Repetitive behaviors / rituals <input type="checkbox"/> Health problems <input type="checkbox"/> Chronic pain	<input type="checkbox"/> Abuse: Physical, Emotional, or Sexual <input type="checkbox"/> Seeing people, animals, or things that others cannot see or say are not there <input type="checkbox"/> Hearing voices or noises that others cannot hear or say are not there <input type="checkbox"/> Feeling as if people are following you or watching you <input type="checkbox"/> Problems in school or work <input type="checkbox"/> Problems with relationships <input type="checkbox"/> Parents' pending divorce or separation <input type="checkbox"/> Parents arguing frequently <input type="checkbox"/> Extreme calorie restriction / counting <input type="checkbox"/> Self-induced vomiting <input type="checkbox"/> Using laxatives to control weight <input type="checkbox"/> Weighing yourself daily <input type="checkbox"/> Troubles eating or swallowing <input type="checkbox"/> Fear of gaining weight <input type="checkbox"/> Being bullied <input type="checkbox"/> Bullying others
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X. Personal Strengths:

Please check any of the following characteristics that you consider to be your strengths:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Empathy | <input type="checkbox"/> Creativity | <input type="checkbox"/> Curiosity | <input type="checkbox"/> Open-mindedness |
| <input type="checkbox"/> Integrity | <input type="checkbox"/> Vitality | <input type="checkbox"/> Love | <input type="checkbox"/> Kindness |
| <input type="checkbox"/> Leadership | <input type="checkbox"/> Forgiveness / mercy | <input type="checkbox"/> Humility / modesty | <input type="checkbox"/> Prudence |
| <input type="checkbox"/> Gratitude | <input type="checkbox"/> Hope | <input type="checkbox"/> Humor | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Love of learning | <input type="checkbox"/> Perspective / wisdom | <input type="checkbox"/> Bravery | <input type="checkbox"/> Persistence |
| <input type="checkbox"/> Social intelligence | <input type="checkbox"/> Socially responsible / teamwork | <input type="checkbox"/> Fairness | |
| <input type="checkbox"/> Self-regulation / self-control | <input type="checkbox"/> Appreciation of excellence / beauty | | |

XI. Support:

Please check any of the following you consider to be a source of support:

<input type="checkbox"/> Boyfriend / Girlfriend	<input type="checkbox"/> Parents / Guardians	<input type="checkbox"/> Siblings	<input type="checkbox"/> Close Friend
<input type="checkbox"/> Extended Family (e.g., grandparents)	<input type="checkbox"/> Group of Friends	<input type="checkbox"/> Church / Synagogue / Mosque / Temple	

Your provider may want you to complete additional questionnaires to further assess your symptoms.

Any additional questionnaires may be used to track your progress in treatment.