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# CHILD/TEEN INTAKE QUESTIONNAIRE

Child's Name: _____ Age: ____ DOB: _____
Home Address: _____ Cell Phone: _____
_____ SSN: _____
School: _____ Grade/Teacher: _____

Parent(s)/Guardian's Name: _____ Home Phone: _____
Address (if different): _____
Place of Employment: _____ Work Phone: _____

Please fill out the following if applicable
Non-custodial Parent's Name: _____ Home Phone: _____
Address: _____
Place of Employment: _____ Work Phone: _____
Date of separation/divorce _____ Age of child at that time _____

Who referred you to me? _____
Self ( ), Minister ( ), Physician ( ), Friend ( ), Family ( ), Neighbor ( ), School ( ),
Legal Authorities ( ), Other: _____

Explain your reason for seeking psychotherapy:
_____
_____
_____
_____

## CURRENT HOUSEHOLD

List all the members of the child's family and all others in your home:

| Names | Age/Birth Date | Relationship | Occupation |
|---|---|---|---|

_____
_____
_____
_____
_____
_____
_____

Please circle the problems which pertain to the child:

| | | |
|---|---|---|
| Family History | Depression | Fears |
| Nervousness | Sexual Involvement | Suicidal Thoughts |
| Shyness | Divorce | Obsessions |
| Separation Anxiety | Alcohol Use | Friends |
| Drug Use | Self-Control | Unhappiness |
| Anger | Stress | Academic Problems |
| Sleep | Headaches | Tiredness |
| Legal Matters | Ambition | Stomach Trouble |
| Energy | Insomnia | Making Decisions |
| Loneliness | Inferiority Feelings | Concentration |
| Lack of Attention | Career Choices | Health Problems |
| Temper | Nightmares | Lack of Appetite |
| Argues Frequently | Authority Problems | |

Other/s: _____

If you have consulted mental health professionals/facilities (i.e., hospitals, treatment centers, etc.) in the past, name all of them below (approximate times will be helpful):

| Person/Facility Name: | Treatment Dates: |
|---|---|
| 1. _____ | _____ to _____ |
| 2. _____ | _____ to _____ |
| 3. _____ | _____ to _____ |

(use additional space if needed)

How has the problem/s affected you and significant others (i.e., family, friends)?

_____
_____
_____
_____
_____
_____
_____

(use additional space if needed)

What do you expect as the eventual outcome (your goal) from therapy?

_____
_____
_____
_____

(use additional space if needed)

## FAMILY HISTORY

With reference to the child's family, respond to the following (check all that apply):

| Issue | Explanation |
|---|---|
| ( ) Alcoholism | _____ |
| ( ) Drug Abuse | _____ |
| ( ) Prescription Drug Abuse | _____ |
| ( ) Emotional Abuse | _____ |
| ( ) Child Neglect | _____ |
| ( ) Verbal Harshness | _____ |
| ( ) Sexual Abuse | _____ |
| ( ) Workaholism | _____ |
| ( ) Arrest | _____ |
| ( ) Mental illness | _____ |
| ( ) Family Violence | _____ |
| ( ) Other Stressor | _____ |
| | _____ |

Does the child regularly drink alcohol (once per week)? Yes ( ) No ( )

If so, describe: (type, frequency & duration (years) of use) _____
_____
_____
_____

Does the child regularly use tobacco (daily)? Yes ( ) No ( )

If so, describe: (type, frequency & duration (years) of use) _____
_____
_____
_____

Does the child currently use illegal drugs? Yes ( ) No ( )

Has the child experienced problems related to alcohol/drug use, or health concerns due to tobacco use? Yes ( ) No ( )
If so, describe: _____
_____

Are you currently a participant in a self-help group or program? Yes ( ) No ( )
If so, describe: (frequency & duration of attendance) _____
_____
_____

## HEALTH:

Physician: _____ Phone: _____
Date of last visit: _____ Reason: _____

Current Medications (list all prescription drugs):

| | Medication | Dosage | Reason |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

Over the counter (OTC) medications (list all OTC meds taken regularly):

| | Medication | Dosage | Reason |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

Please describe any problems during pregnancy or early childhood which may be affecting the child currently: _____
_____
_____

Does the child have a history of the following (place a “p” for past problem, a “c” for a current problem, and leave blank for no problem in the area):

( ) Psychiatric problems, ( ) Physical handicap, ( ) Diabetes, ( ) Epilepsy,
( ) Headaches, ( ) Gastro-intestinal distress, ( ) Bowel disturbance, ( ) Fainting,
( ) High blood pressure, ( ) Skin rashes/hives, ( ) Sleep disturbances,
( ) Ob-Gyn symptoms, ( ) Appetite/food problems, ( ) Respiratory distress,
( ) Back pain, ( ) Joint inflammation, ( ) Loss of balance, ( ) Malignancy,
( ) Coordination problems, ( ) Cardiovascular difficulty, ( ) HIV, ( ), Herpes,
( ) Other significant health concerns _____
_____
_____

## SOCIAL/PERSONAL

Religious Involvement: _____
_____
_____

Please describe the child's religious upbringing: _____
_____
_____

Please describe any spiritual goals you have for counseling (if a teen)_____
_____
_____

Please include any data or history that you feel I should know about or ask you about in the first interview: _____
_____
_____
_____
_____
_____
_____
_____

Name of person(s) to contact in case of emergency:

_____ Phone: _____
_____ Phone: _____