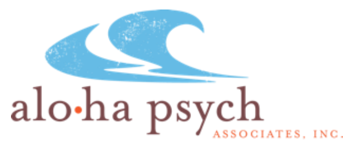

MINOR INTAKE QUESTIONNAIRE

All information is confidential and will not be released without written consent or as required by law

Name of Child/Adolescent:		Date of Birth	Age
Ethnicity/Race	Primary Language	How were you referred to our office?	

What brings you to our office? Briefly describe your current difficulties.

___

___

___

___

___

Home Environment:

Who does the child live with? ______________________ Parent's marital status: ______________

Please describe the current relationship between the child's biological parents: ______________

___

Parent's names (please list even if the child has no contact):

	Name	Age	Occupation	Education level
Mother				
Father				
Step-parent				
Step-parent				

Please list all siblings:

Name	Age	Sex	Do they live with the child in question? If not where do they live?

All information is considered confidential

Concerns: Please indicate which of these has caused **significant** problems:

Last 2 weeks	Ever		Last 2 weeks	Ever	
		Problems in school			Social problems
		Eating problems			Sleeping problems
		Victim of abuse			Perpetrator of abuse
		Sexual concerns			Traumatic event
		Memory problems			Removed from home due to abuse/neglect
		Nightmares			Wets the bed
		Sadness			Bites nails
		Change in appetite			Worry
		Irritability			Jittery / jumpy / restless
		Loss of interest in others			Nausea / stomachaches
		Talk about hurting self			Headaches
		Mood swings			Wants to hurt someone else
		Bangs head			Difficulty making friends
		Is bullied / teased			Gets into fights
		Bully / threatens / teases others			Has used a weapon
		Defiant to adults / refuses to obey			Physically cruel (animals or people)
		Refuse to go to school / skips school			Lies
		Steals			Argues with adults
		Often loses temper			Blames others for his/her problems
		Deliberately annoys people			Angry / resentful
		Easily annoyed by others / touchy			Uses drugs / alcohol
		Spiteful / vindictive / seeks revenge			Sets fires
		Temper tantrums			Destroyed property
		Runs away			Daydreams
		Easily distracted			Makes careless mistakes
		Difficulty focusing			Does not follow through on instructions
		Does not seem to listen when spoken to			Avoids homework / schoolwork
		Difficulty organizing tasks			Fidgets
		Loses things			Runs or climbs excessively
		Leaves seat when should be seated			Always on the go (never sits still)
		Difficulty playing quietly			Blurts out answers before the question is asked
		Talks a lot			Interrupts others
		Trouble waiting turn			Poor handwriting
		Clumsiness			Stuttering

All information is considered confidential

Medical History:

Current primary care provider: ________________________________ Phone Number _______________

Date of last visit: _______________ Reason for last visit ________________________________

Any current medical problems: ____

Any significant childhood illnesses/injuries: ____

Please list all current medications (both prescription and over-the counter):

Medication	Prescribed by	For	Dosage	Side-Effects

Allergies:

Developmental History:

Was this a planned pregnancy? ☐ Yes ☐ No Was the pregnancy full term? (not premature or late) ☐ Yes ☐ No

Were there any complications during the pregnancy? ☐ Yes ☐ No If so please list: _______________

____

Was there any exposure to anything harmful during pregnancy? (toxins, drugs or alcohol, diseases) ☐ Yes ☐ No

Were there any complications during the delivery? ☐ Yes ☐ No If so please list: _______________

____

Child's birth weight: ___________________ Length at birth: ______________________

Approximately how old was the child when he/she first:

Crawled: __________ Walked: ________________ Sat up alone: __________________

Talked: ________________ Was toilet trained: ________

Substance Use:

Are there any concerns about substance use for this child? ☐ Yes ☐ No

If yes, what substances has this child used (that you are aware of)?

Alcohol Marijuana Cocaine Heroin Methamphetamines Inhalants Other

Has the child ever been in treatment for substance usage problems? ☐ Yes ☐ No

All information is considered confidential

Psychological Treatment History:

Family Psychological History

	Psychological/Emotional/Substance Use Issue (depression, anxiety, ADHD, alcoholism)	Any Treatment	Ever Hospitalized for Psychological/Emotional/ Substance Use Issues
Mother			
Father			
Siblings			
Other Relatives			

Please list all previous psychotherapy, counseling, or psychiatric hospitalization for this child:

Dates	Provider	Focus of Treatment

Has your child ever made a suicide attempt? ☐ Yes ☐ No if yes when?____________________

What occurred?____

____

How did the family cope with this crisis? ________________________________

____

Are you aware of any: ☐ Physical abuse ☐ Sexual Abuse ☐ Emotional Abuse

Legal History: **If no legal history please check here:** ☐

Please list all contacts with the police this child had had:

Date	Reason for Contact	Outcome

Are there any currently have any legal involvements, including civil actions (being sued) and custody disputes involving this child? ☐ Yes ☐ No Please list:________________________________

____

All information is considered confidential

Educational History:

Current school: ________________________ Grade Level: ____________________

Teacher's Name: ______________________ School Counselor's Name: ________________

How is this child doing in school?:____

Are any of the following true for this child:

✓		✓	
	Difficulty making friends		Participated in extracurricular activities (i.e sports/clubs)
	Teased / Bullied by others		Difficulty concentrating in class
	Suspended or Expelled		Tutoring
	Getting into physical fights		Attended special program
	Repeated a grade / Held back		Failed a class
	Truancy / Skipped class frequently		Changed schools due to a move
	Refused to go to school		Attended pre-school (i.e. Headstart)
	Skipped a grade		Tested for learning problems / ADHD

Daily Living:

Are there any other supportive agencies involved with this child? (Marigold, church groups, ESD, etc.):

☐ Yes ☐ No Please list:____

What does this child enjoy doing?: ____

What are this child's greatest strengths? : ____

Other:

Is there anything else that is important for me to know that is not listed on this form? If so please write about it here:

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