



## CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

\*It is Important to complete this in its entirety and to have it with you at the time of first appointment

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Your Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

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### Presenting Problem

1. What is your major concern that led you to seek help?

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2. What other concerns do you have?

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3. Is there a particular reason you are seeking an appointment now?

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### Psychological History

4. Has the child ever had a psychological evaluation or had intellectual or achievement testing? Y N

If yes, describe when, with whom and what the results were. (Please attach any evaluations that have been done for your child).

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5a. Has the child ever been seen by a psychiatrist, psychologist or counselor, or have you ever sought help for these problems before? Y N

5b. If yes, please write name(s) and address(s) of professional(s).

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5c. Explain what happened and result for each.

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**Medical Information**

6. Name and address of your child's current physician or pediatrician.

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7. What is your child's current health? Is the child being treated for anything?

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8. Has your child ever taken medication for attention, behavior or mood problems?    Y    N

9. Please indicate any medications your child is currently taking or has taken.

Medication			
Dosage			
Purpose			
Date Started & Ended			
Physician			
Side Effects (if any)			

10. Explain your child's eating habits, restricted diet, food or eating limitations, weight concerns. Has the child ever been tried on any special diets? \_\_\_\_\_

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11. What physical or exercise activities is your child involve in?

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12. (Adolescent females only) What problems, if any, does your child have with unusual depression, irritability or discomfort during her menstrual cycle?

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13. Please indicate any of the following sleep problems that your child has, (if any), by rating the severity of the problem; Mild, Moderate, Severe.

\_\_\_\_\_ Difficulty waking in the morning      \_\_\_\_\_ Frequent waking during night      \_\_\_\_\_ Snoring  
\_\_\_\_\_ Difficulty falling asleep                      \_\_\_\_\_ Nightmares (bad dreams)                      \_\_\_\_\_ Bedwetting  
\_\_\_\_\_ Not rested after sleep                      \_\_\_\_\_ Sleeping too much                      \_\_\_\_\_ Delaying bedtime  
\_\_\_\_\_ Physically restless sleep                      \_\_\_\_\_ Teeth grinding

14. Has your child suffered any of the following?

Problem	Explain frequency, age, etc.
Serious Illness	_____
High Fever	_____
Convulsions	_____
Operations	_____
Accidents	_____
Unconsciousness	_____
Allergies	_____
Hospitalizations	_____
Vision Problems	_____
Hearing Problems	_____
Head Injury, Concussion	_____

15. Are there any current physical problems? Y N If so, explain \_\_\_\_\_  
\_\_\_\_\_

16. Has your child had any physical symptoms/problems to a bothersome degree such as: asthma, pneumonia, fainting spells, vomiting spells, dizzy spells, nose bleeds, constipation, frequent colds, earaches, headaches, diarrhea, and/or stomach complaints?  
\_\_\_\_\_  
\_\_\_\_\_

17. Would you say your child was sickly? Y N If so, explain \_\_\_\_\_  
\_\_\_\_\_

18. Any other information that would be of help? \_\_\_\_\_  
\_\_\_\_\_

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### Family History

19. Does your child or any family member have or had any of the characteristics listed below please indicate and write in their relationship to the child. (Ex. father, mother, grandfather, aunt, etc.; if unknown please state)

	Child	Other Relatives
Reading difficulties	_____	_____
Spelling difficulties	_____	_____
Left handedness	_____	_____
Speech difficulties	_____	_____
Math difficulties	_____	_____
Writing problems	_____	_____
Hyperactivity	_____	_____
Attention problems	_____	_____
Depression	_____	_____
Anxiety	_____	_____
Sleep disorder	_____	_____
Obsessive Compulsive	_____	_____
Mood swings	_____	_____
Anger Management	_____	_____
Addictions (alcohol, drugs)	_____	_____
Violent or criminal behavior	_____	_____
Migraines/headaches	_____	_____
Seizures	_____	_____

## Developmental History

### 20. Pregnancy

Was child adopted? Y N If so, at what age? \_\_\_\_\_  
Was Assisted Reproductive Technology (ART) involved in your child's conception? Y N If so, what means?  
\_\_\_\_\_  
Any illnesses during pregnancy? \_\_\_\_\_  
At what stage of pregnancy? \_\_\_\_\_  
Any medication taken by mother? \_\_\_\_\_  
RH Factor? Y N Was child transfused? Y N

### 21. Birth

How many weeks pregnant did you give birth? \_\_\_\_\_ Birth weight \_\_\_\_\_  
Was labor prolonged? (12 hours or more) \_\_\_\_\_  
Was this a Caesarean section? Y N  
Was there birth trauma? (forceps, breech, anoxia) \_\_\_\_\_  
Was your child placed in an incubator? Y N Explain \_\_\_\_\_  
If so, explain \_\_\_\_\_  
Was the child discolored at birth? Y N Explain \_\_\_\_\_  
If so, explain \_\_\_\_\_  
Were there any medical problems after birth? \_\_\_\_\_  
\_\_\_\_\_  
Released from hospital after \_\_\_\_\_ days.

### 22. Childhood

When did your child walk without assistance? \_\_\_\_\_  
When did your child speak? Words \_\_\_\_\_ Phrases \_\_\_\_\_ Sentences \_\_\_\_\_  
Any speech or language problems? Y N If so, explain \_\_\_\_\_  
\_\_\_\_\_  
Was English your child's first language? Y N  
At what age was toilet training accomplished? Bladder \_\_\_\_\_ Bowel \_\_\_\_\_  
Explain any problems \_\_\_\_\_  
\_\_\_\_\_  
Did bedwetting continue? Y N If so, how long? \_\_\_\_\_  
Any separations from family? Y N If so, at what age and explain reason \_\_\_\_\_  
\_\_\_\_\_  
Was your child extremely physically active or always "on the go"? Y N  
Were there any disruption or major difficulties that could have affected the child's bonding with his or her mother during the first three years? Y N If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

### 23. Has the child shown any of the following?

Temper tantrum	Y N	Persistent thumb sucking	Y N
Unusual fears	Y N	Walking in sleep	Y N
Eating problems	Y N	Accident prone	Y N
Rocking/head banging	Y N	Extremely physically active	Y N
Clumsiness	Y N		

Explain \_\_\_\_\_  
\_\_\_\_\_

23A. Has your child ever suffered a head injury, concussion or traumatic brain injury (tbi)? If yes, explain \_\_\_\_\_  
\_\_\_\_\_

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### Home Life

24. What are the child's current living conditions? If the parents, are divorced, who has custody and what are the visitation agreements? \_\_\_\_\_  
\_\_\_\_\_

25. How well does your child get along with his/her parents?

Mother/StepMother \_\_\_\_\_

Father/Step Father \_\_\_\_\_

26. If the child is not living with both natural parents, what is his/her relationship with the non-custodial parents? \_\_\_\_\_

27. If birth parents are not together, how well do they get along, especially in regards to your child? \_\_\_\_\_

28. Do parents agree on discipline? Y N If not, explain \_\_\_\_\_

29. Who disciplines your child at home and how? \_\_\_\_\_

30. List any other children in the child's family or any other person's living in the home.

Name	Relationship to child	Birth date	Living in home?

31. How well does the child get along with siblings? \_\_\_\_\_

32. Is there a set time and place for your child's homework activity? Explain \_\_\_\_\_

33. How much time does your child usually spend doing homework on a school night?

30 mins. or less     1 hour     2 hours     3 or more hours

34. From after school until bedtime, how much time does your child usually spend watching television?

5 hours or more     4 hours     3 hours     2 hours     1 hour or less     none

35. If your child plays video games, how much time is spent per day?

5 hours or more     4 hours     3 hours     2 hours     1 hour or less     none

36. If your child plays video games, what is the highest rating level that your child plays?

EC (Early Childhood)     E (Everyone)     T (Teen)     M (Mature)     A (Adult)

37. How many hours does your child usually spend on leisure reading after school?

5 hours or more     4 hours     3 hours     2 hours     1 hour or less     none

38. What is/are your child's chores/responsibilities at home? \_\_\_\_\_

39. Does your child participate in sports or demonstrate any special talents? \_\_\_\_\_

**School**

40. Did your child attend nursery school, day care, or private kindergarten? Y N

41. How did your child adjust to the above experience? Liked \_\_\_\_\_ Disliked \_\_\_\_\_ Resisted \_\_\_\_\_

Please explain \_\_\_\_\_

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42. Is your child currently on an individualized Education Plan (IEP)? Y N  
If so, please attach most recent IEP.

43. Specify any private tutoring or summer school that was pursued. \_\_\_\_\_

44. Please describe your child's greatest strengths and any special abilities or talents. In what school subjects has he or she generally done best? \_\_\_\_\_

45. Has your child ever repeated a grade? Y N If so, list grade and explain. \_\_\_\_\_

46. Has your child learned as well as expected? Y N If no, explain \_\_\_\_\_

47. Does your child get along well with other students? Y N If no, explain \_\_\_\_\_

48. Does your child get along well with teachers? Y N If no, explain \_\_\_\_\_

49. Is there a set time and place for your child's homework activity? Y N Explain \_\_\_\_\_

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### **Psychosocial History**

50. How does your child get along with friends and peers? \_\_\_\_\_

51. Does your child have problems either understanding or expressing emotions? Does your child have problems with social awareness? \_\_\_\_\_

52. To your knowledge, has your child used tobacco, alcohol, marijuana or other drugs? Y N  
If so, explain \_\_\_\_\_

53. Any problems in social network such as death or loss of close friends, rejection by peers, or frequent moves causing loss of friends? \_\_\_\_\_

54. Educational problems including learning problems, problems with teachers or classmates, ridicule or bullying? \_\_\_\_\_

55. Problems with housing, living arrangements or sudden loss of family income? \_\_\_\_\_

56. Medical problems, illness or surgeries? \_\_\_\_\_

57. Problems related to the police, or interaction with legal system, being a victim or a crime or a ward of the court? \_\_\_\_\_

58. Exposure to a disaster, accidents or other trauma? \_\_\_\_\_  
\_\_\_\_\_

59. Problems in family such as separation, divorce or remarriage of a parent; psychiatric, alcohol or drug problems of parent or sibling, death or serious health problems of a family member, change in living arrangements? If so, list age of child, nature and affect it had on the child. \_\_\_\_\_  
\_\_\_\_\_

60. Any emotional, physical or sexual abuse; neglect, or exposure to domestic violence? If so, list age of child, nature and affect it had on the child. \_\_\_\_\_  
\_\_\_\_\_

61. What are your child's hobbies, interests or activities?  
\_\_\_\_\_  
\_\_\_\_\_

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### Attention Problems

62. What problems, if any does your child have with daydreaming, staying on-task or being disorganized? At what age did you first notice this? Do the problems occur mainly at home, at school, or in both places? \_\_\_\_\_  
\_\_\_\_\_

63. What problems, if any, does your child have with hyperactivity, stimulus seeking or feeling restless? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places? \_\_\_\_\_  
\_\_\_\_\_

64. What problems, if any does your child have with impulsivity or acting without thinking of consequences? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places? \_\_\_\_\_  
\_\_\_\_\_

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### Oppositionality, Anger and Conduct Problems

65. How cooperative is your child? If asked to do 5 things during a day, how many would they do correctly on the first request, without arguing or delaying? \_\_\_\_\_ How much do you feel the problem is with being defiant and uncooperative versus distractible or disorganized? \_\_\_\_\_  
\_\_\_\_\_

66. What problems, if any does your child have with irritability and anger? When angry, is the child more likely to let the anger go quickly or hold onto resentment? \_\_\_\_\_  
\_\_\_\_\_

67. Does your child ever become violent or destructive? Have they ever hurt anyone intentionally or threatened to kill someone? Have they ever been cruel to animals? What interest does the child have in weapons? \_\_\_\_\_  
\_\_\_\_\_

68. What problems, if any, does your child have with authority or with getting into trouble, unlawful activity or delinquent actions that could cause legal consequences? \_\_\_\_\_  
\_\_\_\_\_

69. In relating to others, what problems, if any, does your child have in terms of being cruel, manipulative or failing to show remorse when appropriate? \_\_\_\_\_  
\_\_\_\_\_

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### Depression

70. What problems does your child have with their feeling being too easily hurt? Are there any signs of problems with self-esteem? Are there particular things about him or her self your child feels bad about? \_\_\_\_\_  
\_\_\_\_\_

71. What problems, if any, does your child have with sadness, moodiness, withdrawing from friends or activities, looking unhappy, crying easily, or other signs of depression? \_\_\_\_\_  
\_\_\_\_\_

72. Has your child ever talked about wishing they were dead or discussed or attempted suicide? \_\_\_\_\_  
\_\_\_\_\_

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### **Anxiety**

73. What problems, if any, does your child have with fears, tension, anxiety, panic attacks, phobias, being very uncomfortable in new situations or extreme shyness? How has that changed over time? \_\_\_\_\_  
\_\_\_\_\_

74. How likely is your child to complain of not feeling well that may be related to stress or anxiety? \_\_\_\_\_  
\_\_\_\_\_

75. Does your child show intense fear, helplessness, upset or avoidance around anything that reminds them of any trauma such as having been a victim of, or witness to, violence, or having been in an accident? Y N  
If so, please describe \_\_\_\_\_  
\_\_\_\_\_

76. Are there any ideas, fears or concerns about which your child obsesses or worries? \_\_\_\_\_  
\_\_\_\_\_

77. Does your child have any habits, rituals or other compulsive behaviors? \_\_\_\_\_  
\_\_\_\_\_

78. Does your child have any habits, rituals or other compulsive behaviors? \_\_\_\_\_  
\_\_\_\_\_

79. What problems does your child have with muscle or verbal tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming. \_\_\_\_\_  
\_\_\_\_\_

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### **Other Problems**

80. Does your child prefer to be alone or show little interest in having close relationships, with peers outside family (but not shy)? \_\_\_\_\_  
\_\_\_\_\_

81. Is your child's style of speech "odd" (too exact, unusual tone or too formal)? \_\_\_\_\_  
\_\_\_\_\_

82. Does your child tend to become overly fascinated by one particular topic or become an expert on one particular subject such that it is all they want to talk or learn about? (The topics may change as they become older) \_\_\_\_\_  
\_\_\_\_\_