Intake Questionnaire-Child 2 to 17

Client Name: _____

Date: _____

Thank you for completing this questionnaire to help us better understand your child. If at any point you feel like you need more space please write on the back of the sheet, or if you are completing electronically there is space for more information at the end.

Completed by:_____ Child's Date of Birth: _____

Why are you seeking help now, as opposed to earlier or later? What are your primary concerns?

Medical History

Allergies: _____

List ALL current medications, supplements, or regular over the counter medicines taken:

Name of medication	Dose	How often is it taken?

Are there any other psychiatric medications you have taken in the past?

Mark a ✓ next to current or past medical conditions for the client and family members and provide more information if needed

✓	Condition	Who in the family and describe if needed
	Thyroid disease	
	Liver disease	
	Kidney disease	
	Diabetes	
	Cancer	

	COPD/Emphysema	
	Chronic fatigue	
	Hepatitis C	
	High cholesterol	
	Irritable bowel syndrome	
	Anemia	
	Frequent ear infections	
	Sickle cell disease	
	Broken bones	
	Bedwetting	
	Vitamin deficiency	
	Epilepsy/Seizures	
	Migraines	
	Head trauma/concussion	
	Asthma	
	Fibromyalgia	
	Chronic pain	
	Heart disease	
	High blood pressure	
	HIV	
	Gastrointestinal/GI concerns	
	Heart defects	
	Bleeding concerns	
	Dislocated joints	
	Snoring	
	Trouble waking up	
	Other	
	Other	

List any surgeries your child has had:

How would you rate your child's physical health: ◯ Poor ◯ Satisfactory ◯ Good ◯ Very Good ◯ Excellent

List any specific health problems you are currently having:

How would you rate your child's sleep: ◯ Poor ◯ Satisfactory ◯ Good ◯ Very Good ◯ Excellent

Describe any sleep problems your child is currently having:

How much physical activity does your child get each day? _____

Please describe any challenges your child has with food: _____

Brain/Mental Health and Substance Use Treatment History

Please tell us about any other therapy/counseling your child has participated in:

Please tell us about your child seeing a psychiatrist or other provider for psychiatric medication management:

Please tell us about any inpatient or residential treatment your child has received for their brain/mental health:

Please tell us about any drug or alcohol treatment your child has participated in:

Have you or anyone in your family been diagnosed with or treated for:

Condition	**Who**	**Condition**	**Who**
Anxiety		Depression	
OCD		Bipolar Disorder	
Personality Disorder(s)		Eating Disorder(s)	
Post-Traumatic Stress		Schizophrenia	
Substance abuse		Suicide attempt(s)	
ADHD		Other:	
Other:		Other:	

If you are aware of any drug use by your child please describe here, we will ask your child about drug and alcohol use if deemed appropriate by the clinician:

Please describe caffeine (pop, energy drinks, coffee etc.) intake by your child:

Does anybody in the home use nicotine/tobacco products: _____

Has your child ever tried to hurt themselves? _____

Has your child ever tried to harm others? _____

Religion/Spirituality:

Please describe for us important family traditions or activities:

Does your child and/or your family identify with a religion: _____

Education History:

What grade is your child in (or entering in the fall):_____At which school: _____

If your child has an IEP or 504 plan, please describe accommodations:

Family History:

Tell us about your family, is the child living with their parent(s)____yes____no

This child's parents are:____together____married____separated____divorced____never married

____ other: _____

List everyone living in the home, including siblings, please include ages and relationship to child:

Legal History:

Describe any legal involvement your child has had, include divorce/custody arrangements. If the child is under guardianship or was adopted we will need a copy of the court order, if the child's parents are divorced we will require a copy of the divorce decree and contact information for any parents who are not present for appointments:

Treatment Planning:

What are your child's strengths/what are they best at:

How would you describe your child's wants and needs:

What do you want from therapy for your child?

How will things look when therapy is over?

If you have anything else you want to add, or you needed more space for anything above use this space:

Early Development and Home Background (EDHB) Form—Parent/Guardian

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions to Parent or Guardian: Questions P1-P19 ask about the early development and early and current home experiences of your child. Some questions require that you think as far back as to the birth of your child. Your response to these questions will help your child's clinician better understand and care for your child. Answer each question to the best of your knowledge or memory.

What is your relationship with the child receiving care? _____

Please choose one response (✓ or x) for each question.						
Early Development		**No**	**Yes**	**Can't Remember**	**Don't Know**
P1.	Was he/she born before he/she was due (premature)?	○	○	○	○
P2.	Were the doctors worried about his/her medical condition immediately after he/she was born?	○	○	○	○
P3.	Did he/she have to spend any time in a neonatal intensive care unit (NICU)?	○	○	○	○
P4.	Could he/she walk on his/her own by the age of 18 months?	○	○	○	○
P5.	Has he/she ever had a seizure?	○	○	○	○
P6.	Did he/she ever lose consciousness for more than a few minutes after an accident?	○	○	○	○
Early Communication					
P7.	By the time he/she was age 2, could he/she put several words together when speaking?	○	○	○	○
P8.	Could people who didn't know him/her understand his/her speech by the time he/she reached age 4?	○	○	○	○
P9.	Have you ever been concerned about his/her hearing or eyesight?	○	○	○	○
P10.	By the time he/she was age 4, was he/she interested in playing with or being with other children?	○	○	○	○
Home Environment					
P11.	Was there ever a time when he/she could not live at home and someone else had to look after him/her?	○	○		○
P12.	Has he/she ever been admitted to the hospital for a serious illness?	○	○	○	○
P13.	Does anyone at home suffer from a serious health problem?	○	○		○
P14.	Does anyone at home have a problem with depression?	○	○		○
P15.	Does anyone at home regularly see a counselor, therapist, or other mental health professional?	○	○		○
P16.	Does anyone at home have a problem with alcohol, drugs, or other substances?	○	○		○
P17.	Would you say that the atmosphere at home is usually pretty calm?	○	○		○
		Less Than Once a Month	**Between Once a Week and Once a Month**	**More Than Once a Week**	**Most Days**
P18.	How often are there fights or arguments between people at home?	○	○	○	○
P19.	How often does your child get criticized to his/her face by other family members when he/she is at home?	○	○	○	○

David Shaffer, F.R.C.P., F.R.C., Psych.