



Child & Adolescent Intake Questionnaire

Child's Name: _____ Age: _____ Date: _____

Your Name(s): _____ Relationship to Child: _____

PRESENTING PROBLEM AND PRIOR TREATMENT

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

2. What other concerns do you have?

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

4. Has the child ever had a psychological evaluation or had intellectual or achievement testing at school?

No _____ Yes _____ If yes, describe when, with whom and what were the results.

5. Has the child ever been in counseling, or have you ever sought help for these problems

No _____ Yes _____ If yes, enter the information below.

<p>Date(s) and number of visits of most recent counseling:</p> <hr/> <p>Who did you see?</p> <hr/> <p><i>Explain what happened and the results:</i></p>
<p>Date(s) and number of visits of any earlier counseling:</p> <hr/> <p>Who did you see?</p> <hr/> <p><i>Explain what happened and the results:</i></p>

6. Has the child ever taken medication for attention, behavior or mood problems? No _____ Yes _____

If yes, carefully enter the following information for each medication in the table below.

MEDICATION			
DOSE			
REASON PRESCRIBED			
DATES TAKEN			
PRESCRIBING PHYSICIAN			
BENEFITS			
PROBLEMS			
IF DISCONTINUED WHY?			

MEDICAL HISTORY

7. Has the child been to the doctor in the last year? No _____ Yes _____ If yes, were the current concerns discussed and if so, what recommendations were made? _____

8. How is the child's health currently? Are you being treated for anything? _____

9. Is the child allergic to anything including medications? No _____ Yes _____ If yes, Please describe. _____

10. Has the child had any of the following? Mark an "X" and the ages when noted and then describe below

	(X)	Ages when happened
Allergies or food sensitivities	_____	_____
Ear infections, frequent colds	_____	_____
Poisoning or drug overdose	_____	_____
Serious illnesses or surgeries	_____	_____
Vision/hearing difficulties (not glasses)	_____	_____
Speech disorders	_____	_____
Serious accidents/injuries	_____	_____
Any blows to the head or concussions	_____	_____
Any loss of consciousness or seizures	_____	_____
Very sensitive to feel of labels, seams, textures in clothes	_____	_____
Bothered by loud or unexpected noises	_____	_____
Very picky eater	_____	_____

11. Does the child get headaches? No _____ Yes _____ If yes, Please describe the type, frequency and severity? _____

12. List any medications the child is **currently** taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

DEVELOPMENTAL HISTORY

13. Were there any problems or unusual circumstances during the pregnancy, delivery or first months of your life?

No _____ Yes _____ Don't know _____ If yes, please describe.

14. Was the child adopted? No _____ Yes _____ If yes, at what age? _____

15. Were there any developmental problems including delay in learning to crawl, walk or talk?

No _____ Yes _____ Don't know _____ If yes, please describe.

16. As an infant, was the child difficult, demanding, hard to soothe, colic or had problems sleeping?

No _____ Yes _____ Don't know _____ If yes, please describe.

17. Were there any disruption or major difficulties that could have affected your bonding with your mother during the first three years of childhood? No _____ Yes _____ Don't know _____ If yes, please describe.

18. As a child, was the child extremely physically active or always on the go?

No _____ Yes _____ Don't know _____ If yes, please describe.

PSYCHOSOCIAL HISTORY

19. Please describe any of the following the child has experienced.

Problem Areas	Age(s)	Nature of event and impact on child
<p>Problems in your family while you were growing up, such as separation, divorce or remarriage; psychiatric, alcohol or drug problems of parent, death or serious health problems of family member, change in living arrangements</p>		
<p>Emotional, physical or sexual abuse; neglect, or exposure to domestic violence or on-going intimidation, harassment, discrimination</p>		

Name _____

SOCIAL RELATIONS

Problem Areas, cont...	Age(s)	Nature of event and impact
<p>Problems in social network such as death or loss of close friends rejection by peers, or frequent moves causing loss of friends</p>		
<p>Educational problems including learning problems, with teachers or classmates, ridicule or bullying</p>		
<p>Problems with housing, living arrangements or sudden loss of family income, such as homelessness, frequent moves or suddenly not having family income</p>		
<p>Medical problems, illness or surgeries</p>		
<p>Problems related to the police, or interaction with the legal system, being a victim of a crime or a ward of the court</p>		
<p>Exposure to disaster, accidents or other trauma</p>		

SOCIAL RELATIONS AND SUPPORT

20. What are the child's current living arrangements? If the parents are divorced, who has custody and what are the visitation arrangements

21. How well does the child get along with his/her parents?

Mother/step-mother: _____

Father/step-father: _____

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

23. If birth parents are not together, how well do they get along, especially in regards to the child?

24. How well does the child get along with siblings?

25. How well does the child get along with other friends and peers?

26. Does your child have problems either understanding or expressing emotions? Does your child have problems with social awareness? _____

SCHOOL AND WORK HISTORY

27. What is your child's current grade? _____

28. What was the Grade Point Average on the most recent report card? _____

29. Is your child currently on an Individualized Education Plan (IEP), and if so, for what problem areas?

30. Please mark with an "X" when any of the following has been a serious problem.

	PRESCHOOL KINDERGARTEN	ELEMENTARY SCHOOL	MIDDLE SCHOOL	HIGH SCHOOL
Reading difficulties	_____	_____	_____	_____
Math difficulties	_____	_____	_____	_____
Writing difficulties	_____	_____	_____	_____
Poor grades	_____	_____	_____	_____
Homework problems	_____	_____	_____	_____
Behavior problems at school	_____	_____	_____	_____
Peer problems	_____	_____	_____	_____
Hating school	_____	_____	_____	_____
Resource or special education classes	_____	_____	_____	_____
After-school or summer tutoring	_____	_____	_____	_____

31. What things have you tried at home to solve any of the problems noted above?

32. Please circle any of the following that are **current** problems:

- Reading problems marked by difficulty sounding out words, guessing at words or reading smoothly
- Problems tracking while reading (losing place, missing words, complaining of headaches or eyes hurting)
- Difficulty understanding math calculations
- Difficulty understanding math concepts

- Difficulty at written composition
- Difficulty spelling
- Poor handwriting (even if writing slowly)
- Difficulty drawing or copying figures
- Poor sense of direction
- Poor balance or coordination, clumsy

33. Please describe your greatest strengths and any special abilities or talents. In what school subjects has he or she generally done best? _____

ATTENTION PROBLEMS

34. What problems, if any does the 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?

35. What problem, if any, does the 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?

36. What problem, if any, does the child have with impulsivity, impatience 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?

OPPOSITIONALITY, ANGER AND CONDUCT PROBLEMS

37. How cooperative is the child? If asked to do 10 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?

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

ATTENTION PROBLEMS

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

40. What problems, if any, does the child have with authority or with getting in trouble, unlawful activity or delinquent actions that could cause legal consequences?

41. 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?

DEPRESSION

42. What problems do you have with your feeling being too easily hurt? Are there any signs of problems with self-esteem? Are there particular things about yourself you feel especially bad about?

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

44. Has the child ever talked about wishing they were dead or discussed or attempted

ANXIETY

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

46. How likely is the child to complain of not feeling well that may be related to stress or anxiety?

47. Does the 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?

No _____ Yes _____ If yes, please describe.

48. Are there any ideas, fears or concerns about which the child obsesses or worries?

49. Does the child have any habits, rituals or other compulsive

50. What problems does the 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.

OTHER PROBLEMS

51. Does the child prefer to be alone or show little interest in having close relationships with peers outside family (but not shy)? _____

52. Is the child's style of speech "odd" (too exact, unusual tone or too formal)?

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

54. Does the child become unduly upset by changes in routine?

SUBSTANCE USE

55. Does the child use tobacco or tried to smoke? Yes_____ No_____

56. Does the child drink coffee? How much other caffeinated beverages do they drink?

57. Do you have any knowledge or suspicion that the child has drank alcohol? if so describe.

58. Do you have any knowledge or suspicion that the child has used drugs? If so describe.

OTHER HEALTH RELATED MATTERS

59. What problems, if any, has the child had with eating, sugar cravings, dieting or maintaining weight? How healthy and eater is the child? Has the child ever been tried on any special diets? _____

57. For each of the following, please identify **any relatives** (children, siblings, parents, grandparents, aunts or uncles) who may have had problems in these areas (i.e. "One of Mom's sisters took medication for depression.", "One of Dad's brothers drank heavily from age 15 to 40 and then went into treatment").

Check here if father's family history is unknown. () *Check here if mother's family history is unknown.* ()

Problems with attention including
being distractible, hyperactive or
impulsive

Problems in school or problems learning
to read, write or do math.

Problems with oppositionality, anger,
violence or criminal behavior

Depression or Anxiety

Headaches / migraines / seizures
neurological problems

Alcohol Problems
Drug abuse

Serious health problems

Other mental or emotional illness

**Thank you for
completing this form!**

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