

CHILD INTAKE QUESTIONNAIRE

CLIENT INFORMATION:

Date: _____

Name of Child: _____

Date of Birth: _____ Age: _____

Address: _____

Telephone Numbers (day) _____ (evening) _____

Can messages be left at day number? _____ Can messages be left at evening number? _____

Parent(s)/Guardian(s) Names: _____

Parent(s)/Guardian(s)' Marital Status:

Single Married Committed Relationship Separated Divorced Widowed

If parents are separated/divorced, please indicate who has custody of child:

Referred by: Name _____

Address & Telephone _____

Family Physician: Name _____

Address & Telephone _____

Emergency Contact Person: Name _____ Address _____

Telephone (Day) _____ (Evening) _____

CURRENT DIFFICULTY:

Please indicate the reason that you are seeking services for your child at this time. Describe the nature of your child's difficulties and any family difficulties, including how long they have been present: _____

Please check the severity of your child's difficulties:

mildly upsetting moderately upsetting severe very severe extremely severe

Have you consulted anyone about your child's difficulties? If so, please indicate name, title, address, and telephone number:

Has your child ever received counselling/treatment/hospitalization for emotional difficulties? Yes ___ No ___ If yes, please describe when and reasons for previous treatment:

Has your child ever received medication for emotional difficulties? Yes ___ No ___ If yes, please describe the name, how much, how frequently, and with what results:

Check off all that currently apply to your child:

- | | |
|--|---|
| <input type="checkbox"/> family problems | <input type="checkbox"/> stress or burnout |
| <input type="checkbox"/> behavioural problems | <input type="checkbox"/> anger/frustration |
| <input type="checkbox"/> friendship problems | <input type="checkbox"/> easily agitated/annoyed |
| <input type="checkbox"/> school performance problems | <input type="checkbox"/> eating problems |
| <input type="checkbox"/> irritability | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> low energy/fatigue |
| <input type="checkbox"/> fears/phobias | <input type="checkbox"/> physical illness |
| <input type="checkbox"/> anxious thoughts/worries | <input type="checkbox"/> mean to others |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> disobedient |
| <input type="checkbox"/> low self-esteem | <input type="checkbox"/> lying |
| <input type="checkbox"/> shyness | <input type="checkbox"/> stealing |
| <input type="checkbox"/> loneliness | <input type="checkbox"/> trouble with the law |
| <input type="checkbox"/> depression | <input type="checkbox"/> running away |
| <input type="checkbox"/> self-mutilation | <input type="checkbox"/> temper outbursts |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> alcohol/drug problems |
| <input type="checkbox"/> daydreaming/distractable | <input type="checkbox"/> traumatic issues |
| <input type="checkbox"/> concentration problems | <input type="checkbox"/> grief/losses |
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> strange thoughts or behaviours |
| <input type="checkbox"/> excessive behaviours | <input type="checkbox"/> Other problems: |
| <input type="checkbox"/> difficulties controlling impulses | _____ |

What are major stresses that your child and family are facing at this time? _____

What do you wish for your child to accomplish from therapy? _____

What changes (e.g. feelings, behaviours, etc) would you like to see in your child? _____

What changes would you like to see in your family? _____

What changes would you like to see in yourself? _____

CHILD'S PERSONAL HISTORY:

Please list any medical and/or health difficulties that your child is currently experiencing:

Is your child taking any medication? If yes, please indicate the name, how much, how frequently, and with what results?

Has your child ever been hospitalized? Yes ___ No ___

If yes, please explain: _____

Please list any family history of illness: _____

Please list any family history of emotional difficulties: _____

Does your child drink alcohol or use any other substance? Yes ___ No ___ Unsure ___

If yes or unsure, please indicate what kind of substance(s) your child uses:

Has your child experienced any life events that were particularly distressing or traumatic for him/her? Yes ___ No ___

If yes, please describe: _____

How does your child generally cope with stressful or upsetting circumstances (e.g. distract him/herself, seek help, become emotional, keeps to him/herself)?

What are current interests, activities, sports, or hobbies that your child enjoys? _____

Please describe your child's strengths: _____

FAMILY INFORMATION:

Please describe who lives with your child. If your child lives in multiple residences, please describe living arrangements including who lives with your child at each residence:

Please indicate number of moves in your child's life: _____

Marital History of Parents (please check all that apply):

Natural Parents: ___ married when: _____
 ___ separated when: _____
 ___ divorced when: _____
 ___ deceased M or F when: _____

Stepparents: ___ stepmother when involved in child's life: _____
 ___ stepfather when involved in child's life: _____

Other significant partner: ___ when involved in child's life: _____

If parents are separated/divorced:

How much contact does your child have with his/her natural mother? _____
How much contact does your child have with his/her natural father? _____

How many brothers and sisters does your child have? _____

Please list their gender and ages: _____

Does your child have any step-siblings or half-siblings? Yes ___ No ___

If yes, please list their gender and ages: _____

Please give a short description of your child's relationship with his/her siblings:

Please describe your relationship with your child including strengths and areas of concern:

Please describe your child's relationship with other caretakers including strengths and areas of concern: _____

Briefly describe any significant past relationships your child may have had with others: _____

CHILD'S DEVELOPMENTAL HISTORY

Prenatal & Birth History:

Length of Pregnancy: _____ Normal Pregnancy? Yes ___ No ___

If mother was ill, upset, or experienced any pregnancy complications, please explain:

Length of active labour ___ hrs _____ Easy Labour ___ Difficult Labour _____

Type of Delivery: ___ spontaneous ___ cesarean ___ breech ___ with instruments

Child's Birth Weight: ___ lbs. ___ oz.

Did child experience any complications at birth? Yes ___ No ___

If yes, please describe: _____

Newborn/Toddler Period:

Did your child experience any of the following complications:

Irritability Yes ___ No ___ If yes, how long: _____

Vomiting Yes ___ No ___ If yes, how long: _____

Difficulty sleeping Yes ___ No ___ If yes, how long: _____

Colic Yes ___ No ___ If yes, how long: _____

Difficulty eating Yes ___ No ___ If yes, how long: _____

Difficulty gaining weight Yes ___ No ___ If yes, how long: _____

Convulsions/seizures Yes ___ No ___ If yes, how long: _____

Ear infections Yes ___ No ___ If yes, how long: _____

Difficulty attaching to others Yes ___ No ___ If yes, how long: _____

Separation anxiety Yes ___ No ___ If yes, how long: _____

Other: _____ Yes ___ No ___ If yes, how long: _____

Developmental Milestones:

Age at which your child:

Sat up _____

Crawled _____

Walked _____

Spoke single words _____

Spoke sentences _____

Toilet trained _____

Please indicate if there were any difficulties with developmental milestones: _____

Who generally disciplines your child: _____

What form of discipline do you use with your child (e.g. time-out, grounding, removal of privileges, yelling, spanking)? _____

Please describe how your child generally responds to discipline including any areas of difficulty: _____

CHILD'S EDUCATIONAL & OCCUPATIONAL HISTORY

Child's highest grade/level completed: _____

Has your child experienced any difficulties in school? Yes ___ No ___

If yes, please describe (e.g. academic, behavioural, social): _____

Does your child have any specific learning disabilities? Yes ___ No ___

If yes, please describe: _____

Does your child attend school on a regular basis? Yes ___ No ___

Has your child ever been suspended or expelled? Yes ___ No ___

If yes, please describe: _____

Please indicate the nature of your child's relationships with siblings and peers:

___ individual play ___ group play ___ competitive ___ cooperative ___ leader ___ follower

Please describe the nature of your child's friendships (e.g. number and gender of friends, closeness of your child's relationships): _____

Please describe any difficulties your child has experienced with peers (e.g. fighting, frequent conflicts, few friends, victim of teasing or bullying): _____

Has your child ever been employed? Yes ___ No ___

If yes, please describe nature of your child's occupation and how long your child has been working there: _____

OTHER:

Please add any information not brought up by this questionnaire that may aid your psychologist in understanding and helping your child.
