INTAKE QUESTIONNAIRE

Confidential and Privileged Information

Please complete the following form to help us understand your child. This will decrease the time needed to make an accurate evaluation of your child's needs. Please print or type information.

Identifying Information

Form Completed By: _____ Date:_____

Child's Name: _____ Current Age: _____

Grade: _____ Date of Birth: _____ Assigned Sex: Male Female

Gender Identity: Male Female Transgender Male Transgender Female Nonbinary

Race/Ethnicity: _____

Home Address: _____

City _____State _____ Zip code _____

Home Phone Number: _____ Okay to leave a message? Yes No

Cell Phone Number: _____ Okay to leave a message? Yes No

Work Phone Number: _____ Okay to leave a message? Yes No

Who has legal custody: _____

Pediatrician: _____

Address: _____

_____ Phone Number:_____

Family Information

Mother's Name _____ Birth date _____

Highest school grade completed by mother _____

Mother's occupation/place of employment _____

Father/ Other Parent's Name _____ Birth date _____

Highest school grade completed by father/other parent _____

Father/Other Parent's occupation/place of employment _____

Is your child adopted? _____ No _____ Yes If yes, for how long and any information known about biological parents?:_____

_____

_____

_____

Are parents married? _____ Yes _____ No If yes, when? _____

Are parents separated? _____ Yes _____ No If yes, when? _____

Are parents divorced? _____ Yes _____ NoIf yes, when? _____

Are there step-parent(s) involved? _____ Yes _____ No

If yes, when was the remarriage for either parent? _____

Step-Parent(s) or Legal Guardian(s) Names:_____

Birthdate(s) _____ Occupation(s) _____

Highest grade completed by step-parent(s) _____

Is there any important information about the parents' relationship which might be helpful to know?_____

_____

List all siblings (full, half, step, living or deceased) Name;Age; Sex; Relationship to child; Grade; Living with Child?

1. _____
2. _____
3. _____
4. _____

Please give the name and relationship of anyone else currently living in the home

_____

History of Current Problem

What are your current concerns regarding your child?_____

_____

_____

_____

At what age was the problem first noted? _____ Please describe any illness or injury that may have been associated with the problem. _____

_____

_____

Has your child ever had treatment for this problem? _____

If so, Where? _____ When? _____

Has your child ever had counseling or psychological services for any other problem?

Yes or No

If yes, when and where? _____

_____

Have there been any significant changes, events, or losses in your child's life?

_____

_____

_____

Please circle any of the following areas of concern, past or present.

Anger Management School Problems Problems Completing Work

Obsessions/Compulsions Body Image Physical Complaints/Pain Family Problems

Motor/Vocal Tics Poor Concentration Sleeping Problems Excessive Worry

Depressed Mood Lying Suicidal Thoughts Hallucinations/Delusions

Bullying/Teasing Nightmares Separation Anxiety Hyperactivity Sexual Abuse

Bedwetting/Soiling Self-Injurious Behavior Aggression Medical Issues

Helplessness Shyness Impulse Control Problems Low Self-Esteem

Food Issues Irritability Opposition Distractibility Cruelty to Animals

Birth, Developmental, & Medical History of Child

Birth History: Did mother use any of the following during pregnancy?

Tobacco	Alcohol	Drugs
____ Yes	____ Yes	____ Yes
_____ No	____ No	_____ No

Describe any complications during pregnancy_____

_____

_____

_____

Length of pregnancy: _____ Full Term _____ Premature (at _____ weeks)_____ Late

Type of delivery _____ Birth weight_____

Describe any complications during delivery_____

_____

_____

Were there any medical problems noted at or immediately following birth? _____

_____

_____

Developmental History of Child: Please note the age at which your child reached the following developmental milestones. If unsure of the exact age, give the approximate age. Sat alone _____ Walked alone _____ Potty Trained _____

Started using single words (other than "mama" or "dada") _____

Used 3 word-sentences _____

Infancy or Toddler concerns?_____

_____

Developmental Concerns? _____

_____

Please note any difficulties your child has experienced with the following:

If you are bringing your teenager (12 and over) to the office, does your child have any problems with alcohol or drugs?

Tobacco	Alcohol	Drugs
_____ Yes	_____ Yes	_____ Yes
_____ No	_____ No	_____ No
_____ Unsure	_____ Unsure	_____ Unsure

Medical History of Child: Describe any serious accident, illness, or injury which your child has experienced and what age. Any history of asthma or seizures?_____

_____

_____

_____

_____

Please list any operations your child has undergone and when:_____

_____

_____

Please list any allergies that your child has:_____

_____

_____

List any medications your child is currently taking (name of medication and dosage):

_____

_____

_____

Please list any significant medical problems of anyone in the family.

_____

_____

_____

Please list any family mental health history (Include immediate and extended family members). _____

_____

_____

_____

Educational History of the Child/Teen

Attended Daycare? _____ (*Circle one)* In home daycare Daycare facility At home

Attended Pre-school? ____ Yes____ No Attended Kindergarten?____ Yes _____ No

In gifted program? _____ Yes_____No If yes, describe: _____

Receive special education or additional support? _____ Yes _____ No

Does your child have an Individualized Education Plan (IEP) or 504 _____Yes _____ No

If yes, why does your child have an IEP? _____

_____

Ever had psychoeducational testing? _____ Ever repeated a grade? _____

Ever been suspended or expelled?_____ If yes, what grade and why?_____

_____

Current School: _____ Grade: _____

Type of School: _____ Public _____Private _____Home Schooled

What grades does your child receive? _____

Any recent changes in grades? _____

School Phone Number:_____ Name of primary teacher: _____

Feelings about school work (circle all that apply): Anxious Passive Enthusiastic Fearful No expression Bored Rebellious Tedious

Other: _____

Approach to school work (circle all that apply): Organized Industrious Responsible Interested Self-directed Noinitiative Refuses Does only what is expected Sloppy Disorganized Cooperative Does not complete work

Other: _____

Strengths & Assets of the Child & Family:

What are your child's strengths? _____

_____

_____

_____

_____

What are your family's strengths? _____

_____

_____

_____

_____

What are your family's favorite activities? _____

_____

What does your child do with unstructured time? _____

_____

Please use the space below to note anything else you feel the psychologist should know in helping your child. Feel free to add your own page if needed.

_____

_____

_____

_____

_____

_____

_____