Attention, Behavior & Cognition
Counseling and Psychological Services, LLC.

Child Intake Questionnaire

Confidential and Privileged Information

Please complete the following form to help us obtain important information about your child and decrease the time needed during the initial intake appointment.

Identifying Information:

Form Completed By: _____ Date: _____

Child's Name: _____ Gender: ☐ Male ☐Female

Current Age: _____ Date of Birth: _____ Race/Ethnicity: _____

Pediatrician's Name, Address and Phone Number:

_____

Family Information:

Mother's Name _____ DOB: _____

Highest educational level: _____

Mother's occupation/place of employment: _____

Father's Name _____ DOB: _____

Highest educational level: _____

Father'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 ☐ No? If 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: _____

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

_____
_____
_____

List all siblings (full, half, step) including their name, age, sex, relationship to child, and if they are living in the family home:

_____
_____
_____
_____
_____

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

_____
_____

Presenting or Referral Problem:

Please list the three reasons or concerns that led you to seeking help for your child?

1. _____
2. _____
3. _____

History of Presenting or Referral Problem:

At what age were these concerns first observed? _____

Please describe any illness or injury that may have been associated with the problem:

_____
_____

Has your child ever had treatment for this problem? ☐ Yes ☐ No

If yes, when, where, with whom and was it effective?

_____
_____
_____

Has your child or family ever participated in counseling or psychological services for any other concerns?

☐ Yes ☐ No

If yes, when, where, with whom and was it effective?

_____
_____
_____

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

_____
_____
_____
_____

Please indicate any of the following areas of concern, past or present:

☐Anger Management	☐Anxiety/Excessive Worry	☐ Depressed Mood/Sadness
☐ Irritability	☐ School Problems	☐ School Refusal
☐ Opposition/Defiance	☐ Distractibility	☐ Hyperactivity
☐ Poor Concentration	☐ Self-injurious Behavior	☐ Suicidal Ideation
☐ Impulsivity	☐ Family Problems	☐ Low Self-Esteem
☐ Lying	☐ Social/Relationship	☐ Sleeping Problems
☐ Medical/Physical	☐Body Image	☐ Bullying/Teasing
☐ Nightmares	☐ Abuse/Neglect	☐ Other: _____

Birth, Developmental, & Medical History of Child:

How did the parents feel when they found out the mother was pregnant?

_____
_____

Check all the occurred during pregnancy?

☐ Smoking	☐ Drinking Alcohol	☐ Drug Use
☐ Physical Abuse	☐ Extreme Stress	☐ Lack of Prenatal Care

☐ Other: _____

Describe any significant events or complications during pregnancy:

_____
_____
_____

Birth History:

Birth weight: _____

Premature Birth? ☐ Yes ☐ No. If yes, how many weeks? _____

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

_____
_____
_____

Developmental History:

Please note the age at which your child **first** reached the following developmental milestones. If unsure of the exact age, give the approximate age.

Sat _____ Crawled _____ Walked _____
Started using single words _____ Used 3 word-sentences _____
Toilet Trained: _____

Would you say that your child developed **faster**, **slower**, or at about the **same** rate as other children? (circle one).

Any developmental concerns during the infant or toddler years?

_____
_____
_____
_____

Has your child received Early Intervention services? ☐ Yes ☐ No

If yes, please describe the services:

_____
_____
_____

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

☐ Yes ☐ No ☐ Unsure

If yes or unsure, please explain:

_____
_____

Medical History of Child: Describe any serious accident, illness, or injury which your child has experienced and at what age:

_____
_____
_____

Please list any significant medical procedures 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).

_____
_____
_____

<u>Academic/Education History</u>:

Has your child attended nursery school or daycare? ☐ Yes ☐ No

If yes, from what ages? _____

At what age did your child start Kindergarten? _____ First Grade? _____

Does your child:

- Receive special education or additional support? ☐ Yes ☐ No
- Have an Individualized Education Plan (IEP)? ☐ Yes ☐ No
- Have a 504 Plan? ☐ Yes ☐ No

If yes, why does your child have an IEP or 504 Plan?

_____
_____
_____

Has your child ever:

- Completed psychoeducational testing? ☐ Yes ☐ No
- Repeated a grade? ☐ Yes ☐ No
- Been suspended or expelled? ☐ Yes ☐ No

If yes, please provide additional information (including dates, reason, reports, etc.):
_____
_____
_____
_____

Current School: _____ Grade: _____

Teacher: _____ School Phone #: _____

Type of School: ☐ Public ☐ Private ☐ Home Schooled ☐ Other: _____

What grades does your child receive? _____

Any recent changes in grades? _____

What subject does your child like most/least? _____

Feelings about school work (check all that apply):
☐ Anxious ☐ Passive ☐ Enthusiastic ☐ Tedious
☐ Fearful ☐ Bored ☐ Rebellious ☐ Other: _____

Approach to school work (check all that apply):
☐ Organized ☐ Self-directed ☐ Sloppy ☐ Industrious ☐ Refusal to complete work
☐ Disorganized ☐ Responsible ☐ Interested ☐ Avoidant ☐ Other: _____

How do individuals at school describe your child's behavior?
_____
_____
_____

Describe your child's relationships with teachers and peers:
_____
_____
_____

Is your child involved in any extracurricular activities?
_____
_____
_____

Social:

Please check all that apply to your child:

☐ Other children seek him/her out for play ☐ Seeks out others for play

☐ Prefers to play alone ☐ Other children seem to ignore my child

☐ Argues or fights with other children ☐ Has a best friend.

☐ Is bullied or teased by others

How many friends does your child have?

At home? _____ At school? _____

Please describe any social concerns you may have about your child:

_____
_____
_____

Child & Family Strengths:

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 we should know in helping your child. Feel free to add your own page if needed.

_____
_____
_____
_____
_____
_____