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Intake Questionnaire

Today's Date: _____

Reason For Seeking Help For Your Child

Why are you seeking treatment at this time?

How long ago did the problems begin?

What kinds of interventions have been tried?

Is there a caregiver other than parents? Yes/No

If yes, how often?

Family Background

Child lives with (father/mother/siblings/half-siblings/step-siblings/other). Please list names and age of each person in the same household.

Parent's marital status: Married/Separated/ Divorced

Who has legal custody? _____

Are there any custody considerations of which we should be aware of?

Do either parent travel for work? Yes/No
If yes, how often?

_____

_____

Is child adopted? Yes/No
If yes, where and at what age? _____
If child is adopted, what does child know about the adoption and/or birth family?

Have there been any recent family changes? Yes/No
Describe:

How did the child react?

Describe child's relationship with Mom/parent?

Describe child's relationship with Dad/parent?

Describe child's relationship with siblings?

How would you describe parents' relationship with each other?

Describe Mom/Parent's parenting style/approach with this child:

Describe Dad/Parent's parenting style/approach with this child:

What are you parenting concerns (if any)?

Parent's current tobacco/alcohol/drug use:

Pregnancy/Childbirth Background (If adopted, Please complete re: Birth Mom)

Please describe how mom felt during pregnancy:

Medications and their purpose during pregnancy:

How much alcohol was consumed during pregnancy:

Any illicit drugs used during pregnancy? Yes/No
Name drugs and frequency:

Please list any complications with conception, pregnancy, childbirth:

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How many weeks gestation? _____ Vaginal/C-section

Weight at birth _____ Length at birth _____

Newborn Complications after birth:

Was there anything unusual, different or difficult about this child during the first 12 months of life?

Please describe child's personality as a baby:

Health Background

Child's pediatrician: _____ Phone _____

Please describe any physical, medical, or psychological concerns that would be helpful to treatment:

Are there any other family members with a similar background? If so, who? What? And what treatment received?

Any surgeries/injuries? (include date)

Any vision or hearing issues, ear infections/strep (include approximate ages and frequency), allergies, difficult with coordination, etc?

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Does your child take medication regularly? Yes/No

Name/dosage/Prescribing MD	Purpose	Date Began	Side Effects

Has your child ever been hospitalized for psychiatric reasons?
If so, please give dates, reason and location:

Does your child receive any other services or has s/he had any recent evaluations (e.g. psychiatric, OT, PT, SLP, etc.)? If so, please provide names and contact information on our Release of Information form.

Developmental Milestones (approximate timing is fine)

Crawl:	Sit Up:	Roll Over:	Walk:
Self feed with utensils:		Drink from a cup:	Say first word:
Speak in sentences:		Make eye contact:	Play Patty Cake:
Smile responsively:		Track Objects:	Potty train:
Play with others interactively:		Dress Self:	Tie Shoes:

How does your child handle changes in routine?

Please note specific situation in which your child tends to become upset, angry, scared, withdrawn, etc.

Please describe how you handle these situations:

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How would you describe your child's temperament/personality?

Describe your approach to discipline and how your child responds

What are your child's social strengths?

What are you child's social areas of improvement?

Does your child make friends with peers easily?

Does s/he show interest in other adults easily or cautiously?

How does your child interact with friends?

What time does your child go to bed? _____ Wake up? _____

Does s/he have issues falling asleep, staying asleep or bedwetting? Describe:

Please describe your child's eating habits/appetite

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School Background

Previous schools attended

_____

Describe your child's previous school experiences

How does your child perform academically?

How does your child feel about school?

How does your child perform socially in school?

Please list comments/concerns expressed by teachers/school staff about your child

Has your child ever received school-based social work services or other school based services? Yes/No

Please describe these services (e.g. Were they provided individually/in groups?

What issues were addressed?

If so, how frequently and during which grades?

_____

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Were services helpful? Why or why not?

Does your child have an IEP or 504 Plan? Yes/No

If so, please describe the services your child receives:

******If your child receives and IEP/504 Plan, please provide us with a copy so that we can collaborate on services and help your child obtain goals as best as we can in this setting.***