Child/Teenager Intake Questionnaire

Child/Teen Name: _____

Date of Birth: _____ Sex: Male Female "X"

_____ Prefer to self-describe _____

School: _____ Grade: _____

Primary Address: _____

Please check next to your preferred phone number. If applicable, please indicate if phone numbers are primary client or parent/guardian:

Mobile Phone: _____ Voice Message /Text OK Yes No

Home Phone: _____ Voice Message Ok Yes No

Work Phone: _____ Voice Message Ok Yes No

Other Phone: _____ Voice Message Ok Yes No

E-mail: _____

In case of Emergency, whom may we contact?

Name: _____ Phone: _____

Relationship: _____

Mother's Name: _____ Employer: _____

DOB: _____

Primary Phone Number: _____

Address: _____

_____

Father's Name: _____ Employer: _____

DOB: _____

Primary Phone Number: _____

Address: _____

Step Mother's Name: _____ Employer: _____

DOB: _____

Primary Phone Number: _____

Address: _____

Step Father's Name: _____ Employer: _____

DOB: _____

Primary Phone Number: _____

Address: _____

Siblings: Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Areas of Concern

What issues/concerns causes you to seek treatment for your child/teenager? Please describe.

Do you have any specific goals with regard to his/her treatment?

Do you have any particular concerns/fears with regard to his/her treatment?

Psychological History

Has your child/teenager ever:

Received mental health treatment/previous counseling? Yes / No

When and duration of treatment:

Name and phone number of previous treating therapist:

What was the focus of treatment?

Been subjected to one or more psychological tests? If so, by whom and at what age?

Attempted suicide? Yes / No If yes, at what age?

Been hospitalized for mental or emotional problems? Yes / No

If yes, at what age and for how long?

Is your child/teenager currently taking any medications? Yes / No

If yes, please list:

Prescribed by whom?

Any past medications to treat mental health?

Is your child/teenager currently having suicidal thoughts? Yes / No

Describe Your Child/Teenager's Childhood

Has he/she ever been subjected to verbal, physical, emotional, or sexual abuse? If yes, please explain.

Has he/she ever been a victim of a violent crime? If yes, please explain.

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Medical History

Has your child/teenager ever been diagnosed with a serious illness? Please explain.

Is your child/teen experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

Primary Care Physician name and phone:

Estimated date of last exam:

Have you or your spouse ever been in a 12-step program. Please describe.

Family of Origin

Description of relationship with mother and/or step mother:

Description of relationship with father and/or step father:

Description of relationship with siblings:

Please describe any visitation and/or joint custody agreement, if applicable.

Other Information

Please describe you spiritual or religious identity, if any.

Please describe your child/teens interests, hobbies, and strengths.