LORRAINE WEINER, LMFT

CHILD INTAKE/QUESTIONNAIRE

Directions: Please complete this form with reference to the child/teen for whom you are seeking help.

Client's Name:_____ **Age:**_____ **Date of Birth**:_____

Date Today:_____ **Home and Cell Phone**:_____

STREET ADDRESS:_____

CITY:_____**STATE**_____**ZIP**_____

RESPONSIBLE PARTY INFORMATION
(*Only IF Different from Client Information Above)*

FIRST NAME_____MIDDLE_____LAST_____

BILLING ADDRESS: _____

CITY_____STATE_____ ZIP_____

HOME PHONE_____WORK PHONE_____CELL_____

SOCIAL SECURITY #:_____ DRIVER.S LICENSE #: _____

RELATIONSHIP OF CLIENT TO RESP. PARTY_____

Parent/Guardian Names:

_____

_____

Mother:

_____

Father:

_____

Stepmother:

_____

Stepfather:

_____

Other:

_____

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If parents are divorced/separated, is there a custody order? ___Yes ___ No

(If so, and only one parent is present for the intake, you will be asked to produce a copy of the custody order prior to any subsequent appointments).

Siblings/Other Household Members:
Name: Age: Relationship to child:

_____

_____

_____

_____

_____

_____

Languages Spoken at Home: _____

Reason for seeking treatment:_____

_____

_____

_____

_____

When did the problem start?_____

_____

How would you rate the severity of the problem right now?

0 1 2 3 4 5 6 7 8 9 10
Mild severe

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Problem Checklist

Please indicate which of the problems below are bothering the child at this time:

0=none 1=mild 2=moderate 3=serious 4=severe

0 1 2 3 4 Suicidal Thoughts/behaviors
0 1 2 3 4 Self Harm
0 1 2 3 4 Feels Hopeless
0 1 2 3 4 Feels Worthless
0 1 2 3 4 Irritable
0 1 2 3 4 Sad/Tearful
0 1 2 3 4 Moody
0 1 2 3 4 Bully
0 1 2 3 4 Poor sleep
0 1 2 3 4 Too much sleep
0 1 2 3 4 Nightmares
0 1 2 3 4 Poor concentration
0 1 2 3 4 Excessive worry/fears
0 1 2 3 4 Panic
0 1 2 3 4 Irregular eating habits
0 1 2 3 4 Weight preoccupation
0 1 2 3 4 Nail biting
0 1 2 3 4 Repetitive behaviors
0 1 2 3 4 Thumb sucking
0 1 2 3 4 Soiling in pants
0 1 2 3 4 Bed wetting
0 1 2 3 4 Attention seeking
0 1 2 3 4 Stuttering

0 1 2 3 4 Hears Voices
0 1 2 3 4 Sees things not there
0 1 2 3 4 Fits of rage
0 1 2 3 4 Overly suspicious
0 1 2 3 4 Few friends
0 1 2 3 4 Excessively shy
0 1 2 3 4 Bossy
0 1 2 3 4 Overly sensitive
0 1 2 3 4 Teases others
0 1 2 3 4 Teased by others
0 1 2 3 4 Cruel to others/animals
0 1 2 3 4 Lying
0 1 2 3 4 Stealing
0 1 2 3 4 Fire setting
0 1 2 3 4 Runs away
0 1 2 3 4 Aggression
0 1 2 3 4 Truancy
0 1 2 3 4 Sexual acting out
0 1 2 3 4 Legal problems
0 1 2 3 4 Authority conflicts
0 1 2 3 4 Tics
0 1 2 3 4 Accident prone
0 1 2 3 4 Excessive physical complaints

CHILD'S BIRTH AND EARLY DEVELOPMENT:

Was the pregnancy: Planned Yes/No Desired Yes/No

Was the child adopted: Yes/No

Were any of these substances used during pregnancy?

Alcohol Yes/No Caffeine Yes/No
Drugs Yes/No (Please specify if yes)_____
Cigarettes Yes/No

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How was mother's health during pregnancy?

_____

Birth Weight _____ **Premature** Yes/No **Post mature** Yes/No

Type of Delivery: _____Problems at birth:_____

_____

Feeding difficulties: _____

Sleeping difficulties: _____

Breast fed: _____months Bottle fed: _____months
As an infant, did the child have regular sleeping and eating habits?_____

Age when child:
Sat alone _____ Walked alone_____ Spoke first words _____Crawled_____ Toilet trained _____ Bowel trained _____Spoke first phrases _____ Spoke first sentences_____

Anything unusual about speech development?_____

Describe personality in early childhood_____

_____

_____

***Medical History*:**

Please describe all serious illnesses, accidents and surgeries
Illness/accident/surgery Age Hospital Stay? How Long?

_____

_____

Any other medical concerns?
_____

_____

Age at onset of puberty_____
Age at onset of menstruation_____

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Irregular or absence of menstrual periods **Yes /No**
Seizures **Yes /No**
Any eye problems **Yes /No**
Any hearing problems **Yes /No**
Blackout spells **Yes/No**

Prior psychiatric/psychological treatment, hospitalization or medication: Yes/ No
If yes, where and when?_____

_____

Current medications/doses_____

_____
List all Drug allergies/adverse reactions
_____

DRUG/ALCOHOL HISTORY:
Past or present history of Drug/Alcohol Abuse: Yes/ No
If yes, please describe:_____

_____
Has your child *experimented* with alcohol or drugs? Yes/No/Don't Know_____

Has your child had any police/legal involvement? Yes/ No
If yes, describe:_____

SCHOOL HISTORY:

Name of School:_____

Teacher:_____

Counselor:_____

Grade:_____

***Please circle Yes or No to all responses regarding your child's school experiences*:**

No significant problems Yes /No
Learning disabilities Yes /No
Academic Achievement problems Yes/ No

School avoidance/phobia	Yes/ No
Truancy	Yes/ No
Behavior Problems	Yes/ No
Peer problems	Yes/ No
IEP	Yes /No
504 Plan	Yes/ No

Has your child been achieving about as well as you feel he or she should? Yes /No

What best describes the grades s/he usually gets?
_____ Well Above Average
_____ Somewhat Above Average
_____ Average
_____ Somewhat below average
_____ Well below average

On average, how much time does your child spend on homework nightly?
_____

Does your child participate in extracurricular activities? If yes, please list:_____

_____

_____

Has your child ever been evaluated for ADHD/other learning problems? If so, when, where and by whom? Why was evaluation done? _____

_____

FAMILY HISTORY:

Who has been the primary caregiver of the child _____
Any significant separations during the first three years _____

How does the child get along with (mark the scale from 1-10 and explain why)

Mother: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details_____

Father: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details_____
Stepmother: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details_____
Stepfather: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details_____
Siblings: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well

Details_____
Other: Gets along very poorly 1 2 3 4 5 6 7 8 9 10 Gets along very well
Details_____
Please describe any family history of mental illness, developmental disabilities, alcohol/drug abuse, psychiatric treatment or hospitalizations: _____

_____

_____

Has violence been a part of the marriage or any other important relationship in the child's life? Yes /No
If YES, please describe_____

_____

Is there currently any physical violence or verbal abuse in your home? Yes /No

If YES, please describe:_____

_____
Has child been a victim of sexual, physical, emotional or verbal abuse? Yes /No

If YES, please describe:_____

_____

Significant Events in the Child's Life

1. Death of a parent	**Yes/No**
2. Parents' divorce	**Yes/ No**
3. Parents' separation	**Yes/ No**
4. Death of a close family member	**Yes/ No**
5. Major personal injury or illness	**Yes /No**
6. Illness of family member	**Yes/ No**
7. Change of school	**Yes /No**
8. Pregnancy	**Yes /No**

9. Sexual problems **Yes/ No**
10. Death of a close friend **Yes/ No**
11. Serious relationship problems **Yes/ No**
12. Sibling leaving home **Yes /No**
13. Frequent change of residence **Yes/ No**

Please explain any Yes items: _____

_____

_____

_____

_____

_____

Desired outcome of your child's/ family's treatment:

_____

_____

_____

_____

_____

_____

_____ _____
Parent's/Guardian's signature **Date**

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