Child & Adolescent Intake Questionnaire

Child's Name: _____ Age: _____Date: _____

Your Name(s):_____ Relationship to Child:_____

Presenting problem and prior treatment

1. Who referred you or how did you learn about our services?

_____

_____

2. What is your major concern that led you to seek help?

_____

_____

_____

3. What other concerns do you have?

_____

_____

_____

4. Is there a particular reason you are seeking an appointment now?

_____

_____

5. Is your child or your family currently in counseling or therapy?

_____

_____

6. Has your youngster ever had any evaluations for ADD/ADHD, learning problems or emotional/behavioral concerns?

_____

_____

7. How is your youngster's overall health Excellent ☐ Good ☐ Fair ☐ Poor ☐

8. Is he or she being treated for anything?

_____

_____

9. Has your youngster ever taken medication for attention, behavior, or mood problems? Yes ☐ No ☐

If yes, **carefully** enter the following information for each medication in the table below.

Medication			
Dose			
Reason prescribed			
Age(s) when taken			
Length of time taken			
Prescribing Physician			
Benefits			
Problems			
If discontinued, why?			

List any medications he or she is currently taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

10. Has he or she ever had any:

	Age(s)	Details
Migraines	_____	_____
Chronic pain	_____	_____
Allergies or food sensitivities	_____	_____
Frequent ear infections or colds	_____	_____
Serious illnesses	_____	_____
Major surgeries	_____	_____
Vision difficulties (not glasses)	_____	_____
Tinnitus	_____	_____
Speech or hearing disorders	_____	_____
Serious accidents/Injuries	_____	_____
Head injuries	_____	_____
Seizures	_____	_____
Very sensitive to feel of labels, seams, textures in clothes	_____	_____
Very sensitive to noises	_____	_____
Very picky eater	_____	_____

Developmental and Social History

11. Born where? _____ Raised where? _____

    Was he or she adopted? Yes ☐ No ☐ If yes, at what age? _____

12. Any delays in learning to crawl, walk, or talk? Yes ☐ No ☐ Unsure ☐

13. Was he or she noticeably "hyperactive" as a preschooler? Yes ☐ No ☐ Unsure ☐

14. Was he or she very anxious as a preschooler? Yes ☐ No ☐ Unsure ☐

Adverse Childhood Events

15. Did your child or teenager, ever experience any of the following:

Did a parent or other adult in the household…

Often or very often swear at, insult, or put them down?	Yes ☐	No ☐
Often or very often act in a way that made them afraid that they would be physically hurt?	Yes ☐	No ☐
Often or very often push, grab, shove, or slap them?	Yes ☐	No ☐
Often or very often hit them so hard that they had marks or were injured?	Yes ☐	No ☐

Did an adult or person at least 5 years older ever…

Touch or fondle them in a sexual way?	Yes ☐	No ☐
Have them touch their body in a sexual way?	Yes ☐	No ☐
Attempt any type of sexual intercourse with them?	Yes ☐	No ☐
Actually have any type of sexual intercourse with them?	Yes ☐	No ☐
Did they ever live with anyone who was a problem drinker or alcoholic?	Yes ☐	No ☐
Did they ever live with anyone who used street drugs?	Yes ☐	No ☐
Was a household member depressed or mentally ill?	Yes ☐	No ☐
Did a household member attempt suicide?	Yes ☐	No ☐

Was their mother (or stepmother)…

Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her?	Yes ☐	No ☐
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?	Yes ☐	No ☐
Ever repeatedly hit over at least a few minutes?	Yes ☐	No ☐
Ever threatened with, or hurt by, a knife or gun?	Yes ☐	No ☐
Did a household member go to prison?	Yes ☐	No ☐

Social relations and support

16. What are your child's current living arrangements? If the parents are divorced, who has custody and what are the visitation arrangements?

_____

_____

17. How well does your child currently get along with his/her parents?

Mother/step-mother:_____

_____

Father/step-father:_____

_____

18. How well do the parents with whom the child is living agree there is a problem and how it should be handled?

_____

_____

19. If your child is not living with both natural parents, what is his/her relationship with the non-custodial parents?

_____

_____

20. If birth parents are not together, how well do they get along, especially in regards to your child?

_____

_____

21. How well does your child get along with siblings?

_____

_____

22. How well does your child get along with other friends and peers? Has your child had problems with either being bullied or bullying?

_____

_____

Current Stresses

			How long has this been a problem?	How stressful? (1= Mild, 10= Very)
23. Are any of the following **currently** a source of stress in your youngster's life?				
Concerns about parents' marriage	Yes ☐	No ☐	_____	_____
Adjusting to a separation/divorce	Yes ☐	No ☐	_____	_____
Siblings who have problems	Yes ☐	No ☐	_____	_____
Loss of friends/social isolation	Yes ☐	No ☐	_____	_____
School problems	Yes ☐	No ☐	_____	_____
Concerns about family finances	Yes ☐	No ☐	_____	_____
Recent deaths/losses	Yes ☐	No ☐	_____	_____
Health problems	Yes ☐	No ☐	_____	_____
Other: _____			_____	_____

Details:_____

_____

School History

24. What is your youngster's current school? _____ Current grade? _____

What were the most recent grades in English/Reading/Language Arts: _____ Math: _____

Science :_____ Social Studies: _____ PE: _____ Electives: _____

25. Has your youngster ever had

An Individualized Education Plan (IEP)? Yes ☐ No ☐ For: _____ Grades (s) _____

A 504 Plan of Accommodation? Yes ☐ No ☐ For: _____ Grades (s) _____

Special Ed or Resource Room class? Yes ☐ No ☐ For: _____ Grades(s) _____

26. Please mark your youngster's typical grades for each subject.

	Elementary School	Middle School	High School
Reading	_____	_____	_____
Math	_____	_____	_____
Writing	_____	_____	_____

And put a check mark where your youngster has had problems:

Homework	☐	☐	☐
Behavior at school	☐	☐	☐
Peer relations	☐	☐	☐
Attitude about school	☐	☐	☐

27. If school has been a problem, were any of the following tried in a consistent way?

			What grade(s)?	Helpful?
Systematic Rewards	Yes ☐	No ☐	_____	_____
Tutoring	Yes ☐	No ☐	_____	_____
Home schooling	Yes ☐	No ☐	_____	_____
Medications	Yes ☐	No ☐	_____	_____
Therapy	Yes ☐	No ☐	_____	_____
Vision, speech or occupational therapy	Yes ☐	No ☐	_____	_____
Repeating a grade or subject	Yes ☐	No ☐	_____	_____

28. Please check any of the following that are current problems:

Difficulty reading	☐	Difficulty spelling	☐
Complains reading hurts or is tiring	☐	Poor handwriting (even if writing slowly)	☐
Difficulty remembering what was read	☐	Difficulty drawing or copying figures	☐
Makes lots of careless mistakes in math	☐	Difficulty keeping track of assignments	☐
Difficulty remembering how to work math problems	☐	Difficulty organizing study time	☐
Difficulty understanding math concepts	☐	Test Anxiety	☐
Difficulty at written composition	☐	Anxiety speaking in class	☐

Attention problems

29. What problems does your youngster have with daydreaming, staying on-task, or being disorganized?

_____

_____

At what age did you first notice this at home? _____ Did teachers ever report this to be something they noticed too?

_____

30. What problems does your youngster have with hyperactivity, stimulus seeking, or feeling restless?

_____

_____

At what age did you first notice this at home? _____ Did teachers ever report this to be something they noticed too?

_____

31. What problems does your youngster have with impulsivity, impatience, or acting without thinking of consequences?

_____

_____

At what age did you first notice this? _____ Has it led your child to hurt or in danger?

_____

Oppositionality, anger, and conduct problems

32. How cooperative is your child? If asked to do 10 things during a day, how many would they do correctly on the first request, without arguing or delaying? _____ How much do you feel that any problems in this area come from his or her not liking to be told to do things versus being distractible or disorganized?

_____

_____

33. What problems does your youngster have with anger? When angry, is he or she more likely to let the anger go quickly or hold onto resentment?

_____

_____

34. When angry, does your youngster's temper frighten others? Does he or she ever become aggressive, violent, or destructive?

_____

_____

35. Has your youngster ever had problems with the law? If so, have those problems continued into the present?

_____

_____

Depression

36. What problems does your youngster have with their feelings being too easily hurt or low self-esteem?

_____

_____

37. What problems does your youngster have with depression?

_____

_____

38. Do you know, suspect, or have concerns that he or she is now thinking of hurting his or herself?
Yes ☐ No ☐ If "yes", please explain _____

_____

Anxiety

39. What problems does your youngster have with fears and anxiety?

_____

_____

40. Are there situations or activities he or she avoids because of anxiety or fear of not doing well?

_____

_____

41. In what ways do stress or anxiety cause physical complaints?

_____

_____

42. Has your child ever suffered a trauma and does he or she continue to show fear or avoidance when reminded of any of these events or being in similar situations? Yes ☐ No ☐ if yes, please describe

_____

_____

43. Does he or she have obsessive worries or compulsive behaviors?

_____

_____

44. What problems does he or she have with muscle or verbal tics? These are repetitive movements such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming.

_____

_____

Alcohol and drug use

45. Has your child tried smoking cigarettes? Yes ☐ No ☐
46. Do you have any knowledge or suspicion that your child has had alcohol without your permission? If so describe.

_____

_____

47. Do you have any knowledge or suspicion that your child has used drugs?

_____

_____

Other Problems

48. Does he or she have problems with social awareness such as not being aware of how another person might be feeling, recognizing unstated rules of what is appropriate" or understanding body language or tone of expression?

_____

_____

49. Is their speaking style "odd" (too exact, unusual tone or too formal)? Does he or she have problems with the rules of conversation? Does he or she have problems knowing when the listener has lost interest?

_____

_____

50. Does he or she become overly fascinated by one particular topic or interest such that it becomes all-consuming?

_____

_____

51. Does he or she become upset by changes in routine or have problems shifting from one activity to another?

_____

_____

52. Does he or she have problems with being either under or overly sensitive to the feel of clothing or to being touched or is he or she both over and under sensitive to pain?

_____

53. Does he or she have problems with being overly sensitive to sounds or noise?

_____

54. Does he or she have problems with being overly sensitive to smells or tastes? Is he or she a very picky eater?

_____

55. Does he or she have problems with being especially sensitive to light or glare? Does he or she complain of room lights being too bright? _____

Other health related behaviors

56. Is there anything unusual about your child's diet or eating?_____

_____

57. How much activity or physical exercise does he or she get? _____

_____

58. Please check any of the following sleep problems your youngster experiences:

Difficulty falling asleep because mind too active	☐	Restless sleep	☐	Sleep walking	☐
Delays going to bed	☐	Sleeps unusual hours	☐	Teeth grinding	☐
Difficulty waking	☐	Nightmares or vivid dreams	☐	Snoring	☐
Frequent waking,	☐	Sleeping too much	☐	Bedwetting	☐
	☐	Fearful to sleep alone	☐	Sleep Apnea	☐

Family History

59. Put the letter symbol in the appropriate spaces.

Parents (M=Mother, F=Father) (History unknown _____)

ADD (distractible)	Suspected _____	Treated for _____
ADHD (hyper/impulsive)	Suspected _____	Treated for _____
Anxiety	Suspected _____	Treated for _____
Depression	Suspected _____	Treated for _____
Alcohol problems	Suspected _____	Treated for _____
Drug problems	Suspected _____	Treated for _____

Siblings (B=Brothers, S=Sisters) (Number of siblings _____)

ADD (distractible)	Suspected _____	Treated for _____
ADHD (hyper/impulsive)	Suspected _____	Treated for _____
Anxiety	Suspected _____	Treated for _____
Depression	Suspected _____	Treated for _____
Alcohol problems	Suspected _____	Treated for _____
Drug problems	Suspected _____	Treated for _____

Grandparents (M = Mother's parents, F = Father's parents) (History unknown _____)

ADD (distractible)	Suspected _____	Treated for _____
ADHD (hyper/impulsive)	Suspected _____	Treated for _____
Anxiety	Suspected _____	Treated for _____
Depression	Suspected _____	Treated for _____
Alcohol problems	Suspected _____	Treated for _____
Drug problems	Suspected _____	Treated for _____