BetsyGiduz LCSW, MSW, MSRA

CHILD INTAKE QUESTIONNAIRE

(to be completed by parent/guardian)

Date _____ Form Completed By _____

Relationship to Child _____

Child's Full Name _____ ☐Male ☐Female Birthdate _____

Address _____

Street City State County Zip

Mother's Name _____ Birthdate _____

Address (*if different from above*) _____

Phones:

Home _____ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Cell _____ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Work _____ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Email _____

Occupation, Employer _____

Father's Name _____ Birthdate _____

Address (*if different from above*) _____

Phones:

Home _____ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Cell _____ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Work _____ May I leave a message w/a person? ☐Y ☐N Voicemail? ☐Y ☐N

Email _____

Occupation, Employer _____

Will you be financially responsible for these services? ☐Yes ☐No

If no, please list responsible party:

Name _____ Relationship to Child _____

Address _____

Phones: Home _____ Cell _____ Work _____

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HEALTH INFORMATION

Pregnancy and Birth: Any complications? ☐Yes ☐No If yes, briefly explain:

_____

_____

Developmental Milestones (ages)

Sitting _____ Walking _____ Talking _____ Toilet trained _____

Current Medical Problems: ☐Yes ☐No If yes, briefly explain:

_____

_____

History of ear infections? ☐Yes ☐No If yes, briefly explain:

_____

Allergies? ☐Yes ☐No If yes, please list:

_____

Sleep problems? ☐Yes ☐No If yes, briefly explain:

_____

Name of Child's Primary Care Physician: _____

Is your child taking any medications? ☐Yes ☐No If yes, please list:

_____

Name of Prescribing Doctor: _____

Has your child received therapy, psycho-educational testing, speech-language therapy, or occupational therapy? ☐Yes ☐No If yes, please list:

Dates	Name of Clinician	Reason for Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

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FAMILY INFORMATION

Parents' Marital Status _____ Date of separation/divorce, if applicable _____/_____

With whom does the child live? _____

Who has physical custody? _____ Legal custody? _____

Who generally disciplines the child? _____

What methods are used? _____

Do parents agree on methods of discipline? ☐Yes ☐No If no, please elaborate:

_____

_____

List all people living with the child in the home:

Name	Age	Relationship	Current Health	Comments
_____	____	_____	Good Fair Poor	_____
_____	____	_____	Good Fair Poor	_____
_____	____	_____	Good Fair Poor	_____
_____	____	_____	Good Fair Poor	_____
_____	____	_____	Good Fair Poor	_____
_____	____	_____	Good Fair Poor	_____
_____	____	_____	Good Fair Poor	_____

Has any other member of the child's immediate family (parents, siblings, grandparents, first cousins) had mental health treatment? ☐Yes ☐No If yes, please elaborate:

_____

_____

_____

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FAMILY RECORD *Indicate with a checkmark the condition and relationship of any blood relative who has or has had any of the conditions listed below.*	None	Client	Father	Mother	Grandfather	Grandmother	Brother	Sister	Other	Indicate Other Relative
Alcoholism/substance abuse										
Allergies										
Anxiety Disorder										
Attention/ADHD Problems										
Birth Defects										
Depression										
Developmental Disorder										
Diabetes										
Eating Disorder										
Learning Disorder										
Migraines										
Mental Illness										
Obsessive-Compulsive Dis.										
Seizure Disorder										
Sensory Issues										
Thyroid Problems										
Tic Disorder										
Other:										

Other Comments:

_____

_____

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SCHOOL INFORMATION

If your child has ever been to a school (including nursery, kindergarten, grade school, and home school), complete the following for all grades beginning with nursery and ending with current placement. Please indicate if your child repeated or is in a special class (gifted/talented, learning disabled, behavior disordered, emotionally handicapped, etc.).

Grade School Comments

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Has your child ever received special accommodations at school according to an Individual Education Plan (IEP) ☐ or 504 Plan ☐? If checked, please elaborate:

_____

_____

Has your child ever received academic tutoring? ☐Yes ☐No If yes, please elaborate:

_____

_____

CURRENT SCHOOL PERFORMANCE *Indicate with a checkmark the child's functioning for each academic subject.*	Failing	Below Average	Average	Above Average	Comments
Reading					
Writing					
Math					
Spelling					
Other subjects: (list)					

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SOCIAL INFORMATION

How many close friends does your child have? ☐None ☐1 ☐2 or 3 ☐4+

Does your child have a best friend? ☐Yes ☐No

Do you approve of your child's friends? ☐Yes ☐No

How many times per week does your child do things with friends outside of school?

☐None ☐1 ☐2-3 ☐4+

Compared to his/her peers, how do you think your child gets along with others?

☐Poor ☐Average ☐Great

Does your child prefer other children who are ☐ younger, ☐ older, or ☐ the same age?

Do you think your child relates better to adults than to his/her peers? ☐Yes ☐No

Please list your child's favorite recreational or extracurricular activities and the approximate number of hours per week he or she spends doing them:

Activity Hours/Week

_____ ☐None ☐1 ☐2 or 3 ☐4+

_____ ☐None ☐1 ☐2 or 3 ☐4+

_____ ☐None ☐1 ☐2 or 3 ☐4+

_____ ☐None ☐1 ☐2 or 3 ☐4+

Please list any chores or responsibilities that your child has at home and how well he or she does these jobs. (For example, feeding the dog, making the bed, etc.)

☐None

_____ ☐Poor ☐Average ☐Great

_____ ☐Poor ☐Average ☐Great

_____ ☐Poor ☐Average ☐Great

What are your child's strengths?

_____

_____

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PARENTAL CONCERNS

What do you feel is your child's main problem?

_____

_____

_____

What do you feel caused the problem?

_____

_____

_____

What have you been told by doctors, teachers and/or others about your child's problems?

_____

_____

_____

Other Comments:

_____

_____

_____

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