Beyond Healing –
A Counseling, Wellness, and Personal Growth Center

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CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

Please use the backs of the pages for additional details.

GENERAL INFORMATION:

Today's Date: _____Person Completing Form:_____

Child's Name: _____Date of Birth: _____Age:_____

Home Address_____

Home Phone (Who are we contacting?):_____

Work Phone (Who are we contacting?):_____

Cell Phone (Who are we contacting?):_____

E-Mail (Who are we contacting?):_____

School: System: Grade:_____

School's telephone number:_____

Teacher(s):_____

Who referred you to our office?_____

Please sign below if you give permission for us to thank this person:

_____

REASON FOR REFERRAL / CURRENT SYMPTOMS

Please describe the problems your child is now having and the type of services you are seeking.

_____

_____

_____

_____

_____

Please indicate if your child is experiencing any of the following difficulties:

_____ School attention/concentration problems

_____ Grades dropping or consistently low

_____ Hyperactive, difficulty being still

_____ Impulsive, doesn't think before acting

_____ Sadness or Depression

_____ Generalized Anxiety (across many situations)

_____ Specific fears/phobias (list)_____

_____ Social Anxiety

_____ Obsessive-Compulsive / Rigid behavior patterns

_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)

_____ Isolated socially from peers

_____ Problems making or keeping friends

_____ Problems with eating

_____ Problems falling asleep

_____ Problems sleeping through the night (middle of the night or early morning waking)

_____ Trouble waking up

_____ Fatigue/tiredness during the day

_____ Nightmares

_____ Noncompliant, purposely does not obey (not due to language or cognitive deficits)

_____ Oppositional, defiant behavior

_____ Problems controlling temper

_____ Tantrums / "Meltdowns"

_____ Problems with authority (breaking rules or laws)

_____ Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)

_____ Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)

_____ Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)

_____ Wetting accidents (indicate day or night wetting):

_____ Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)

_____ History of abuse (emotional, physical, sexual)

_____ Alcohol or drug use/abuse

_____ Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

_____ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

_____ Stress from conflict between parents

_____ Stress due to family financial problems

_____ Legal situation (anyone in family)

_____ Other behavior problems:_____

PARENTS / GUARDIANS AND FAMILY INFORMATION:

Guardian 1's Name:_____ Age: _____

Relation:_____

Occupation: _____ Education Completed:_____

Health: _____Excellent _____Good _____Fair _____Poor

Guardian 2's Name: _____ Age: _____

Relation:_____

Occupation:_____ Education Completed: _____

Health: _____Excellent _____Good _____Fair _____Poor

Relationship Status: _____

If married, how long have you been married? _____

If divorced, how long have you been divorced?_____

If divorced, who has physical custody?_____ Is it full or joint?_____

Who has legal custody? _____ Is it full or joint? _____

Please provide a copy of the custody agreement.

Has either parent been married before or since? Guardian 1: _____ Guardian 2:_____

If yes, provide dates of other marriage(s), names, and ages of children from these marriages:

Guardian 1: Children and ages: _____

Guardian 2: Children and ages:_____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Where does this parent live?_____

If the birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody, with step siblings, etc.? _____

How would you rate the quality of your present marriage?

Guardian 1: Great Very Good Good Fair Poor Very Poor

Guardian 2: Great Very Good Good Fair Poor Very Poor

Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain:_____

Who supervises the child's care when not in school?_____

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

Grade _____

Sibling Name_____ Age_____ School Placement _____ Conduct*

*(Please indicate good, fair, or poor conduct)

In general, how would you say the child for whom you are seeking services gets along with these siblings?

Great Very Good Good Fair Poor Very Poor

Describe:_____

Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.)._____

_____

Name_____ Age _____ Relationship to Child _____ Years Living in Home_____

Name_____ Age _____ Relationship to Child _____ Years Living in Home_____

Are there other relatives who have a significant impact on how this child is raised? _____

FAMILY STRESS LEVEL

Please rate the overall level of FAMILY stress:

_____Very Low _____Low _____Average _____High _____Very High

What is the greatest source of stress for the family at this time? _____ _____ _____ _____

Please rate the overall level of stress in the Guardian 1's life:

_____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in the Guardian 1's life?

_____

Please rate the overall level of stress in the Guardian 2's life:

_____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in the Guardian 2's life? _____

How would you rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Guardian 1: _____ Guardian 2: _____

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who.

Condition	Family Member
_____ General Developmental Delays or Cognitive Delay	_____
_____ Speech or Communication Disorder	_____
_____ Intellectual Disability (mental retardation)	_____
_____ Attention-Deficit / Hyperactivity / Impulsivity	_____
_____ Learning Problems / Disabilities	_____
_____ Autism Spectrum / Asperger's Disorder	_____
_____ Sleep disorders	_____
_____ Generalized Anxiety (across many situations)	_____
_____ Social Anxiety	_____
_____ Obsessive-Compulsive Disorder	_____
_____ Phobias	_____
_____ Depression	_____
_____ Manic-Depression / Bipolar Disorder	_____
_____ Suicide attempts / Suicide	_____
_____ Schizophrenia or other psychosis	_____
_____ Alcohol / Substance Abuse	_____
_____ Seizures or other neurological disorder	_____
_____ Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____

Other:_____

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:_____

_____

DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.

Child was born: _____premature _____at full term _____late

Birth Weight_____ lbs, oz

Difficulties following delivery?

Nursery (check all that apply): _____Well-baby _____Transitional ____Intensive Care _____Other

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.) _____ _____

Any medical problems diagnosed in infancy? _____

As an infant, did this child seem:

_____less active than average _____average _____overly active

As a toddler, did this child seem:

_____ less active than average _____ average _____overly active

As a preschooler, did this child seem:

_____ less active than average _____ average _____ overly active

As the child entered school, did this child seem:

_____less active than average _____ average _____ overly active

At what age did your child accomplish these developmental tasks? If your child has not met one or more

milestones, leave those items blank or write "not yet."

Early On-Time Late Approximate age

(if known)

Speech and Language_____

Coo/babble_____

Respond to name_____

Say first word_____

Use gestures (wave, point) _____

Put words together_____

Speak in sentences_____

Follow simple directions_____

Follow multi step directions_____

Motor Skills_____

Roll over_____

Sit alone_____

Stand alone_____

Walk alone_____

Hold pencil correctly to mark_____

Write legibly_____

Self-Help/Independence_____

Feed self_____

Toilet train (bladder) _____

Toilet train (bowel) _____

Dress self_____

Bathe self_____

Social/Emotional_____

Smile at others_____

Laugh aloud_____

Show affection_____

Engage in pretend play_____

First friendship_____

Control feelings when upset_____

Understand others' feelings_____

Show responsibility_____

MEDICAL HISTORY

Name of Child's Primary Physician: _____

Physician's Address: _____

Physician's Phone: _____

List any other physicians or health professionals your child sees for services on a regular basis.

_____

When was your child last seen by a physician?_____

Rate your child's overall health:

_____Excellent _____Good _____Fair _____Poor

Child's current height: _____ft, _____in. Weight: lbs.

Does your child have any vision problems? _____

Date of last vision test and who performed (physician, optometrist, school)_____

Does your child have any hearing problems? _____

Date of last hearing test and who performed (physician, audiologist, school)_____

Is your child: _____right handed _____left handed _____does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had._____

_____

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List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time. _____

Use the back of the page if needed.

Describe your child's regular diet (i.e, favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating)? _____

What is your child's typical bedtime and wake time each day? _____

Any concerns about your child's sleeping habits?_____

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?_____

_____

EDUCATIONAL AND SOCIAL HISTORY

List in chronological order all schools your child has attended:

Dates Attended	Name of School	Grade Placement	Grade Average Conduct Behavioral
1. From_____ To_____	_____	_____	_____
2 From_____ To_____	_____	_____	_____
3. From_____ To_____	_____	_____	_____
4. From_____ To_____	_____	_____	_____
5. From_____ To_____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)

Name of current teacher (s): _____

What concerns does your child's teacher have about him/her?_____

_____

What is your child's favorite subject?_____

What is your child's least favorite subject?_____

Has your child ever repeated a grade? If so, which?_____

Has your child ever skipped a grade? If so, which?_____

Has your child ever had tutoring? Which subjects?_____

When and with whom? _____

Has this child ever been in a Special Education Program? If so, during what years? _____

How much of the school day?_____

What type of program? (LD, Gifted, EBD, ASD, etc.): _____

Child's attitude toward school: _____

How does your child interact with peers and adults in social situations? _____

Do you have concerns about your child's social skills or development? _____

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

_____Sports (list): _____

_____Music (list):_____

_____Clubs/Groups (list): _____

_____Dance (list):_____

_____ Other: _____

Describe your child's strengths, positive qualities, and any special abilities or skills.

BEHAVIOR MANAGEMENT / DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples.

Please rate how likely you are to use each of the strategies listed: (circle the appropriate number)

Very Unlikely Very Likely

Let situation go 1 2 3 4 5

Time out 1 2 3 4 5

Send to room 1 2 3 4 5

Take away a privilege (ex., no TV) 1 2 3 4 5

Take away something material (ex., no dessert) 1 2 3 4 5

Assign an additional chore 1 2 3 4 5

Ground child 1 2 3 4 5

Reason with child / Problem-Solve / Negotiate 1 2 3 4 5

Yell at child 1 2 3 4 5

Physical punishment 1 2 3 4 5

List anything else you may do:

_____ 1 2 3 4 5

_____ 1 2 3 4 5

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Then, please circle the strategy that is LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Guardian 1:_____% Guardian 2:_____% Other:_____% (Please specify):_____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as doing household chores, care for brothers and sisters, etc.

Would like Child to do More Often Would like Child to do Less Often

1. _____ _____

2. _____ _____

3. _____ ___ _____

4. _____ _____

5. _____ _____

LEGAL HISTORY

Have you ever filed or been involved in any litigation? Please explain

_____

_____

_____

Is there anything else we should know about your child that was not covered by this form?

_____

_____

_____

_____

_____