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 for our time to be efficient. As you complete this form, please feel free to add any additional information which you feel would be helpful. 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.

Please note that if the parents of a child are divorced, we need to have a copy of the court document (parenting/custody agreement) and both parents/guardians need to be notified of counseling.

GENERAL INFORMATION:

Today's Date: _____Person Completing Form:_____

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

Home Address_____

Best Contact Phone (who are we contacting? Specify if work, home, or cell):

_____

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.

_____
_____
_____
_____
_____

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

If yes, where does this parent live: _____

How much contact (in hours/days) does this parent have?_____

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

Please briefly describe if any family member has had any psychological disorder:

_____

_____

_____

_____
_____

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? _____

If/when did you notice changes in the child's temperament?

_____
_____
_____
_____
_____

Are there any developmental tasks or milestones that came late or at all for your child? Please list and describe:

_____
_____
_____
_____
_____

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._____

_____

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 Behavioral Average Conduct
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.:

_____

_____

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):_____

What would be some treatment goals you hope your child and I can work toward?

_____

_____

_____

_____

_____

LEGAL HISTORY

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

_____

_____

_____

What are some positive coping skills/a time your child has worked through something difficult?

_____

_____

_____

_____

_____

What do you love/admire about your child?

_____

_____

_____

_____

_____

What is something your child does well?

_____

_____

_____

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