



INTAKE QUESTIONNAIRE – CHILD

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

Child is (circle one): my biological child my adopted child my foster child Other: _____

IDENTIFYING INFORMATION (for individual receiving services)

Child's Name: _____ Date of Birth: _____

Address: _____ Sex: _____

Work Phone (indicate whose #): _____

Home Phone: () _____ () _____

Social Security Number: _____ Household Income: \$ _____

Who referred you to CSSW? _____

Child's Race:

- | | |
|--|---|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Two or more races |
| <input type="checkbox"/> Unknown | |

Child's Ethnicity:

- Hispanic or Latino
 Non-Hispanic or Non-Latino

Child's Language of Choice:

- | | |
|----------------------------------|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> German |
| <input type="checkbox"/> Russian | <input type="checkbox"/> French |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Other: _____ |

Family's Religious Affiliation:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Catholic | <input type="checkbox"/> Protestant (including Lutheran, Methodist, etc.) |
| <input type="checkbox"/> Muslim | <input type="checkbox"/> Non-Denominational |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> No Affiliation |
| <input type="checkbox"/> Amish | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mennonite | |

Disability:

Do you have a disability? Yes No If yes, please specify: _____

If you have a disability, does the office accommodate your needs? Yes No

If no, please explain: _____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)
- | | | |
|-----------------------|-----------------------|---------------------|
| a. Behavior at home | g. Overactivity | m. Grieving |
| b. Family problems | h. Peer problems | n. Abuse or trauma |
| c. Depression | i. Eating disorder | o. Relationship |
| d. Mood swings | j. Alcohol/drug use | p. Anger |
| e. Behavior at school | k. Physical problems | q. Anxiety or worry |
| f. Self-confidence | l. School performance | r. Other (explain): |
-
-

2. How long has the child had this/these problem(s)? _____

3. Has the child received treatment for this problem or any other problem in the past? Yes No

If yes when, where and with whom? _____

FAMILY HISTORY

1. With whom does the child currently live (names and relationship)? _____

Has the child lived with anyone else in the past? Yes No With whom? _____

2. Please provide the following information about the child (as applicable):

Father's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Mother's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Stepfather's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Stepmother's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____

Foster Father's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Foster Mother's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____
Guardian/Other's Name: _____ Phone #: _____ Address: _____ D.O.B.: _____ Occupation: _____ Education: _____

3. Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (full, half, step, foster)	Lives with Child?		If no, lives where?
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	
			Yes	No	

4. Does the child or any other family member have a history of alcohol or drug problems? Yes No

If yes, please explain: _____

5. Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? Yes No If yes, please describe the circumstances: _____

LEGAL HISTORY

Please describe any involvement the child has had with the legal system (arrests, convictions, probation, parole):

DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal? Yes No I don't know

If no, please explain: _____

2. Did mother use alcohol or other drugs during pregnancy? Yes No I don't know

If yes, please explain: _____

3. Please list any medications taken during pregnancy: _____

4. Did the child reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained - night				

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Please check the appropriate box if the child has experienced any of these problems:

- | | |
|--|---|
| <input type="checkbox"/> Eye disease, injury, poor vision | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ear disease, injury, poor hearing | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Nose, sinus, mouth, throat problems | <input type="checkbox"/> Hemorrhoids, rectal bleeding |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Convulsions or seizures | <input type="checkbox"/> Frequent or severe headaches |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Sleep disturbances |
| <input type="checkbox"/> Extreme tiredness or weakness | <input type="checkbox"/> Neck stiffness, pain, swelling |
| <input type="checkbox"/> Thyroid disease or goiter | <input type="checkbox"/> Marked weight changes |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Allergies or asthma |
| <input type="checkbox"/> Back, arm, leg or joint problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Premenstrual Syndrome (PMS) | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Liver, gallbladder disease | <input type="checkbox"/> Other |

Please explain anything checked above: _____

3. Please provide information about medication(s), prescription or over-the-counter, which the child takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

SCHOOL INFORMATION

1. What school does the child currently attend? _____

2. What is the child's teacher's name? _____

3. What grade is the child in? _____

4. How many schools has the child attended? _____

In which cities/towns were they located? _____

5. Does the child have a written IEP? Yes No

Is the child in special education classes? Yes No Type: _____

6. Is the child experiencing any problems in school?

Academics (grades): Yes No

Behavior: Yes No

Social (peers or adults): Yes No

Please explain any "yes" responses: _____

SOCIAL RELATIONSHIPS / FRIENDS

1. How does the child get along with peers? _____

2. How does the child get along with adults? _____

3. Does the child spend more time with (check the closest answer):

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Same age children | <input type="checkbox"/> Adults |
| <input type="checkbox"/> Older children | <input type="checkbox"/> Mostly alone |
| <input type="checkbox"/> Younger children | |

4. What are the child's hobbies and interests? _____

HOME LIFE

1. Is there a behavior problem at home? Yes No If yes, please explain: _____

2. What are the child's strengths? _____

3. What are the family's strengths? _____

4. What are the child's weaknesses? _____

5. What are the family's weaknesses? _____

6. What kind of discipline is used with the child? _____
Who is the primary disciplinarian? _____

7. Are there any family circumstances you would like us to be aware of? _____

8. What goals would you like to see reached as a result of your child's involvement with CSSW?

9. How will you know when these goals have been reached (describe changes in behavior or functioning)?

THERAPIST REVIEW

Signature: _____

Date: _____