



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: _____ Gender: _____

Work Phone (indicate whose #): _____

Home Phone: () _____ () _____

Cell 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:

Does your child 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 | h. Peer problems | o. Relationship |
| b. Family problems | i. Eating disorder | p. Anger |
| c. Depression | j. Alcohol/drug use | q. Anxiety or worry |
| d. Mood swings | k. Physical problems | r. Sleep problems |
| e. Behavior at school | l. School performance | s. Suicidal thoughts/attempts |
| f. Self-confidence | m. Grieving | t. Other (explain): |
| g. Overactivity | n. Abuse or trauma | |

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? _____
4. What behaviors would you like to see changed as a result of your child's counseling?

FAMILY HISTORY

1. Who does the child currently live with (names and relationship)? _____
2. Has the child lived with anyone else in the past? Yes No
Name: _____
Relationship: _____
How long?: _____
Other: _____
3. Has the child ever lived outside of the parental home (e.g. foster care; with relatives; in a group home)?
a. Yes No If yes, when? _____
b. Please indicate the number of placements the child has had: _____
4. If the child is currently living outside of the parental home:
What is the permanency plan? _____

How often does the child have contact with his/her parents? _____
- Is there a no contact order? Yes No If yes, please explain. _____
5. Has the child been adopted? Yes No If yes, when? _____

6. 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: _____

7. Please provide the following information about the child's brothers and sisters (even if they are not living in the home) and any other non-related children who are living in the home:

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

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

If yes, please explain: _____

9. 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: _____

10. Has the child experienced any type of significant loss or trauma? (e.g. death of a parent or loved one; natural disaster; car accident): 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. Were pregnancy and delivery 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. At what age did the child:

	Age
Sleep through the night	
Sit alone	
Stand alone	
Walk without help	
Say first words	
Talk 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 hospitalizations, operations, injuries (including broken bones): _____

SCHOOL INFORMATION

1. What school does the child currently attend? _____
2. Who is the child’s teacher? _____
3. What grade is the child in? _____
4. How many schools has the child attended? _____

In which cities/towns were they located? _____

5. Is there a school staff person the child really likes? Yes No

What is his/her name? _____

6. Does the child have a written plan at school for learning? Yes No

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

8. Are there any special modifications made at school to accommodate the child?

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

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

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

4. Has the child ever been bullied or teased? Yes No

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

Same age children

Adults

Older children

Mostly alone

Younger children

6. How many friends does your child have? _____

7. How many hours per day does your child use any of the following?

Texting	
Cell phone	
Face Book	
Twitter	
Internet	
Social web site	
Other (explain)	

8. How is your child's use of the above monitored? _____

9. Are you concerned about gangs? Yes No

If yes, please explain: _____

HOME LIFE

1. What does your child do well?

2. What do you like about your child? _____

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

4. What does your family do well? _____

5. What do you like about your family? _____

6. What is difficult for your family? _____

7. What kind of discipline is used with the child? _____
Who is the primary disciplinarian? _____
8. What are the child's chores/responsibilities at home? _____
Does the child have a job outside the home? Yes No
9. Who does the child count on in difficult times? _____
10. Are there any family circumstances you would like us to be aware of?

THERAPIST REVIEW

Signature: _____

Date: _____