Child and Adolescent Intake Questionnaire

Date Completed:

I. IDENTIFYING INFORMATION

Client Name:				
DOB / Age:	/	School / Grade:		
Legal Guardian/s: Street Address: City, State, Zip Code: Telephone:	Home: - - Mobile: - - Mobile: - -	DOB / Age: Occupation: Employer	Guardian 1 /	Guardian 2 /
Non-Custodial Parent (if parents are divorced): Street Address: City, State, Zip Code: Telephone:	Home: - - Mobile: - -	DOB / Age: Occupation: Employer	/	
Foster Parent/s: Street Address: City, State, Zip Code: Telephone:	Home: - - Mobile: - - Mobile: - -	DOB / Age: Occupation: Employer	Foster Par. 1 /	Foster Par. 2 /
Relationship:	☐ Biological	☐ Adopted *Date*:	☐ Foster *Date Placed*:	
Primary Language:				
Client Race/Ethnicity:		**Sex:**	Male ☐ / Female ☐	
Source of Referral:				
Caseworker:				
Funding Source: **Primary Insurance:** **Name of Subscriber:** **Employer:** **Policy Number:** **Group Number:**	☐ Insurance ☐ Private Pay			
Emergency Contact: Telephone:	Home: - - Mobile - -			

II. PROBLEM IDENTIFICATION

Presenting Problem / Reason for Referral

When Did Problems Begin

Identifiable Triggers (things that may have caused or exacerbated the problem)

Impact On Client and Family Functioning

III. FAMILY SOCIAL INFORMATON

Current Family Status

History of Placements/Geographical Relocation(s)

Dates	Caregiver	Location	Child Response

Family History of Mental Health Issues

Family Member	Mental Health Issue	Treatment	Response

Family History of Substance Abuse: -

IV. CHILD SPECIFIC INFORMATION

Educational History:

- **Current School and Grades:**
- **Past Grades:**
- **How does the teacher experience this child**:
- **Suspensions or Expulsions:**
- **Special Education Information**:

Legal History

- **Current Legal Status**:

Lifestyle Issues

- **How does your child interact with other children**?
- **What are your child's Hobbies/Interests/Recreation**:
- **Participation in School/Church/Team activities**:
- **What are this child's strengths**?
- **What are this child's limitations**?
- **Describe this child's support network:**

Parenting Issues

- **How would you describe your parenting style?**
- **How would you describe your spouse' parenting style?**
- **What has worked well in your parenting?**
- **What challenges do you face in this area?**

- **What is one area that you would like to see different in your relationship to your children?**

<u>Marital Issues</u>

- **How would you describe your marriage?**

- **What strengths do you and your spouse bring to the marriage relationship?**

  Your:

  Your Spouse:

- **What growth areas do you and your spouse bring to the marriage relationship?**

  Your:

  Your Spouse:

<u>Spirituality</u>

- **Would you describe spirituality as an important part of your child's life?**

- **Are you involved in any place of worship?**

- **What is your child's religious affiliation?**

- **Would you prefer that issues of faith are a part of counseling services** ☐ **Yes** ☐ **No**

V. TRAUMA HISTORY

Please Check All Trauma Types That Your Child Has or May Have Experienced and Then Provide Additional Information:

Sexual Maltreatment / Abuse / Rape: ☐

Physical Maltreatment / Abuse / Assault: ☐

Emotional Abuse / Psychological Maltreatment: ☐

Neglect: ☐

Domestic Violence: ☐

War / Terrorism: ☐

Medical Trauma / Illness: ☐

Serious Injury / Accident: ☐

Natural Disaster: ☐

Kidnapping: ☐-

Traumatic Loss / Bereavement: ☐

Extreme Interpersonal Violence: ☐

Community Violence: ☐

School Violence: ☐

Forced Displacement: ☐

Impaired Caregiver: ☐

Other Significant Events or Traumas: ☐

VI. CHILD'S HISTORY OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Has your child ever been seen by a therapist, psychologist, or psychiatrist? ☐ Yes ☐ No

Dates of Treatment	Facility & Location	Reason for Treatment	Doctor/ Therapist	Diagnosis

Please List Past Medications

Medication	Dosage & Frequency	Target Symptoms	Doctor

Please List Current Medications

Medication	Dosage & Frequency	Target Symptoms	Doctor

Please List Any Current Illness or Conditions

Illness/Condition	Date Began to Date Ended	Medications	Doctor

Treatment for Substance Abuse: Yes ☐ No ☐ If yes, location:

Client History of Substance Abuse:				
Substance:	**Quantity**	**Frequency**	**Age Began**	**Duration**
Tobacco				
Alcohol				
Marijuana				
Other				
Other Addictive Behaviors:				

Female Clients Only: Currently Pregnant? ☐ Yes / ☐ No / ☐ N/A

VII. PLEASE IDENTIFY CURRENT / PAST SYMPTOMS (place an "X" in appropriate boxes)

Symptoms	Current	Past	None	Symptoms	Current	Past	None
Mood Changes				Mania			
Sleep Disturbance				Grandiosity			
Appetite or Weight Change				Pressured Speech			
Crying				Distractibility			
Irritability				Racing Thoughts			
Loss of Interests				Hypersexuality			
Withdrawal				Goal Directed Beh.			
Energy Level Change				Pleasure Activity			
Memory Difficulties				Decreased Sleep			
Low Self-Esteem							
Helplessness				Hyperactivity			
Hopelessness				Impulsivity			
Somatization				Inattentive			
				Easily Distracted			
Hypervigilance (always alert)				Fidgets			
Re-experiencing				Can't Follow Instruction			
Intrusive Thoughts				Losses Things			
Flashbacks							
Nightmares				Panic Attacks			
Checking out (dissociation)				Excessive Anxiety			
Numbing (can't or won't feel)				Heart Palpitations			
Inability to remember trauma				Persistent Fear			
Avoidance				Trembling			
				Sweating			
Physical Aggression				Short of Breath			
Verbal Aggression				Excessive Worry			
Oppositional Stances							
Rule Violation				Obsessions			
Property Destruction				Compulsions			
Bullying							
Lying				Self-Mutilation/injury			
Theft							
Temper Tantrums				Delusions			
Disrespect				Hallucinations			
				Disorganized Speech			
Poor Eye Contact				Disorganized Behavior			
Indiscriminate Affection							
High Control Need				Misses Social Cues			
Resists Comfort / Closeness				Poor Peer Relations			
Food Issues				Lack of Reciprocity			
Superficially Charming				Inflexible			
Lack of Empathy for Others				Repetitive Motor			
Poor Cause and Effect				Signif. Preoccupation			
Lacks Enjoyment with Others				Language Delays			
				Elimination Issues			
Suicidal Thoughts				Homicidal Thoughts			
Suicide Plans				Homicidal Threats			
Suicide Attempts/Gestures				Homicidal Plans			
Hospitalization	- Times			Hospitalization	- Times		

Are You Aware of Any Current Mental Health Diagnosis?

Your Goals for Services:

Additional Information that Your Child's Therapist Should Know: