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# Child/Adolescent Intake Questionnaire

*Please fill out this intake evaluation completely. Your information will be held in strict confidence according to confidentiality laws and statutes and will help me in evaluating and treating your child.*

Full Name of Child: _____

Date of Birth: _____ Place of Birth: _____ Gender_____

Address: _____

City/State/Zip: _____ Phone: _____

Cell Phone: _____May I Text? (circle) Yes No

Email:_____

Referred by:_____

Primary Physician: _____

**Parents**:

Mother's Name: _____ Father's Name:_____

Birthdate/Age: _____ Birthdate/Age:_____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone # _____

Occupation _____ Occupation_____

Please state what concerns you have about your child at this time and how long you have been concerned. _____

_____

_____

_____

_____

Please list all individuals living in your child's home, their relation to your child, and each individual's age: _____

_____

_____

_____

Please list your child's strengths or areas of success: _____

_____

_____

_____

Activities outside of school that your child may be actively involved in (sports teams, church, etc.): _____

_____

_____

Please state all methods of discipline you use with your child and if these methods have successfully worked (changed the behavior): _____

_____

_____

_____

Please state what you hope to achieve, improve, or change through counseling:

_____

_____

_____

Please list any recent stressors or changes in your environment that may be affecting your child (divorce or marital problems, death in the family, move to a new home / school / neighborhood, etc.): _____

_____

_____

_____

## Medical History

Please list any developmental delays or problems your child had as an infant and toddler (e.g., weaning, walking, sitting up alone, toilet training, talking): _____

_____

_____

Please list any problems your child has had, or currently has, with sleep, eating habits, or elimination (e.g., difficulty with urination, having normal bowel movements, or soiling undergarments): _____

_____

_____

Please list any medical conditions your child currently has, or has had in the past (e.g., ear infections, allergies, etc.) hospitalizations, or surgeries (dates/reasons):

_____

_____

_____

_____

_____

Medications your child *routinely* takes, or has taken in the past:

_____

_____

_____

Please list any previous mental health providers and date/reason: _____

_____

_____

Any additional information you would like the therapist to know:

_____

_____

_____

*Thank you very much for taking the time to complete this form.* (2018)