

## Child & Adolescent Intake Questionnaire

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Your Name(s): \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

### Presenting problem and prior treatment

1. Who referred you or how did you learn about our services?

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2. What is your major concern that led you to seek help?

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3. What other concerns do you have?

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4. Is there a particular reason you are seeking an appointment now?

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5. Is your child or your family currently in counseling or therapy?

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6. Has your youngster ever had any evaluations for ADD/ADHD, learning problems or emotional/behavioral concerns?

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## Health and Medical History

7. How is your youngster's overall health Excellent \_\_\_ Good \_ Fair \_ Poor

8. Is he or she being treated for anything?

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9. Has your youngster ever taken medication for attention, behavior, or mood problems? Yes No

If yes, **carefully** enter the following information for each medication in the table below.

Medication			
Dose			
Reason prescribed			
Age(s) when taken			
Length of time taken			
Prescribing Physician			
Benefits			
Problems			
If discontinued, why?			

List any medications he or she is currently taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

10. Has he or she ever had any:	Age(s)	Details
Migraines	_____	_____
Chronic pain	_____	_____
Allergies or food sensitivities	_____	_____
Frequent ear infections or colds	_____	_____
Serious illnesses	_____	_____
Major surgeries	_____	_____
Vision difficulties (not glasses)	_____	_____
Tinnitus	_____	_____
Speech or hearing disorders	_____	_____
Serious accidents/Injuries	_____	_____
Head injuries	_____	_____
Seizures	_____	_____
Very sensitive to feel of labels, seams, textures in clothes	_____	_____
Very sensitive to noises	_____	_____
Very picky eater	_____	_____

**Developmental and Social History**

11. Born where? \_\_\_\_\_ Raised where? \_\_\_\_\_

Was he or she adopted? Yes  No  If yes, at what age? \_\_\_\_\_

12. Any delays in learning to crawl, walk, or talk? Yes  No  Unsure

13. Was he or she noticeably "hyperactive" as a preschooler? Yes  No  Unsure

14. Was he or she very anxious as a preschooler? Yes  No  Unsure

**Adverse Childhood Events**

15. Did your child or teenager, ever experience any of the following:

*Did a parent or other adult in the household...*

- Often or very often swear at, insult, or put them down? Yes No
- Often or very often act in a way that made them afraid that they would be physically hurt? Yes \_ No \_
- Often or very often push, grab, shove, or slap them? Yes No \_
- Often or very often hit them so hard that they had marks or were injured? Yes \_\_\_ No \_

*Did an adult or person at least 5 years older ever...*

- Touch or fondle them in a sexual way? Yes \_ No \_
- Have them touch their body in a sexual way? Yes \_ No \_
- Attempt any type of sexual intercourse with them? Yes \_ No \_
- Actually have any type of sexual intercourse with them? Yes \_ No \_\_\_
- Did they ever live with anyone who was a problem drinker or alcoholic? Yes \_ No \_\_\_
- Did they ever live with anyone who used street drugs? Yes \_ No \_\_\_
- Was a household member depressed or mentally ill? Yes \_\_\_ No \_\_\_
- Did a household member attempt suicide? Yes \_\_\_ No \_

*Was their mother (or stepmother)...*

- Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her? Yes \_\_\_ No \_
- Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Yes \_ No \_
- Ever repeatedly hit over at least a few minutes? Yes \_ No \_
- Ever threatened with, or hurt by, a knife or gun? Yes \_\_\_ No \_\_\_
- Did a household member go to prison? Yes No \_

**Social relations and support**

16. What are your child's current living arrangements? If the parents are divorced, who has custody and what are the visitation arrangements?

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17. How well does your child currently get along with his/her parents?

Mother/step-mother: \_\_\_\_\_

Father/step-father: \_\_\_\_\_

18. How well do the parents with whom the child is living agree there is a problem and how it should be handled?

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19. If your child is not living with both natural parents, what is his/her relationship with the non-custodial parents?

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20. If birth parents are not together, how well do they get along, especially in regards to your child?

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21. How well does your child get along with siblings?

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22. How well does your child get along with other friends and peers? Has your child had problems with either being bullied or bullying?

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**Current Stresses**

How long has this been a problem?      How stressful? (1= Mild, 10= Very)

23. Are any of the following **currently** a source of stress in your youngster's life?

Concerns about parents' marriage	Yes	—	No	—	_____	_____
Adjusting to a separation/divorce	Yes	—	No	—	_____	_____
Siblings who have problems	Yes	—	No	—	_____	_____
Loss of friends/social isolation	Yes	—	No	—	_____	_____
School problems	Yes	—	No	—	_____	_____
Concerns about family finances	Yes	—	No	—	_____	_____
Recent deaths/losses	Yes	—	No	—	_____	_____
Health problems	Yes	—	No	—	_____	_____
Other:	_____		_____		_____	_____

Details: \_\_\_\_\_

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**School History**

24. What is your youngster's current school? \_\_\_\_\_ Current grade? \_\_\_\_\_

What were the most recent grades in English/Reading/Language Arts: \_\_\_\_\_ Math: \_\_\_\_\_

Science : \_\_\_\_\_ Social Studies: \_\_\_\_\_ PE: \_\_\_\_\_ Electives: \_\_\_\_\_

25. Has your youngster ever had

An Individualized Education Plan (IEP)?	Yes	No	—	For: _____	Grades (s) _____
A 504 Plan of Accommodation?	Yes	No	—	For: _____	Grades (s) _____
Special Ed or Resource Room class?	Yes	No	—	For: _____	Grades(s) _____

26. Please mark your youngster's typical grades for each subject.

	Elementary School	Middle School	High School
Reading	_____	_____	_____
Math	_____	_____	_____
Writing	_____	_____	_____

And put a checkmark where your youngster has had problems:

- Homework
- Behavior at school
- Peer relations
- Attitude about school

27. If school has been a problem, were any of the following tried in a consistent way?

	Yes	No	What grade(s)?	Helpful?
Systematic Rewards	Yes ___ No ___	_____	_____	_____
Tutoring	Yes ___ No ___	_____	_____	_____
Home schooling	Yes ___ No ___	_____	_____	_____
Medications	Yes ___ No ___	_____	_____	_____
Therapy	Yes ___ No ___	_____	_____	_____
Vision, speech or occupational therapy	Yes ___ No ___	_____	_____	_____
Repeating a grade or subject	Yes ___ No ___	_____	_____	_____

28. Please check any of the following that are current problems:

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|--|---|
| Difficulty reading                               | Difficulty spelling                       |
| Complains reading hurts or is tiring             | Poor handwriting (even if writing slowly) |
| Difficulty remembering what was read             | Difficulty drawing or copying figures     |
| Makes lots of careless mistakes in math          | Difficulty keeping track of assignments   |
| Difficulty remembering how to work math problems | Difficulty organizing study time          |
| Difficulty understanding math concepts           | Test Anxiety                              |
| Difficulty at written composition                | Anxiety speaking in class                 |

## Attention problems

29. What problems does your youngster have with daydreaming, staying on-task, or being disorganized?

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At what age did you first notice this at home? \_\_\_\_\_ Did teachers ever report this to be something they noticed too?

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30. What problems does your youngster have with hyperactivity, stimulus seeking, or feeling restless?

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At what age did you first notice this at home? \_\_\_\_\_ Did teachers ever report this to be something they noticed too?

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31. What problems does your youngster have with impulsivity, impatience, or acting without thinking of consequences?

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At what age did you first notice this? \_\_\_\_\_ Has it led your child to hurt or in danger?

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## Oppositionality, anger, and conduct problems

32. How cooperative is your child? If asked to do 10 things during a day, how many would they do correctly on the first request, without arguing or delaying? \_\_\_\_\_ How much do you feel that any problems in this area come from his or her not liking to be told to do things versus being distractible or disorganized?

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33. What problems does your youngster have with anger? When angry, is he or she more likely to let the anger go quickly or hold onto resentment?

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34. When angry, does your youngster's temper frighten others? Does he or she ever become aggressive, violent, or destructive?

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35. Has your youngster ever had problems with the law? If so, have those problems continued into the present?

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**Depression**

36. What problems does your youngster have with their feelings being too easily hurt or low self-esteem?

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37. What problems does your youngster have with depression?

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38. Do you know, suspect, or have concerns that he or she is now thinking of hurting his or herself?

Yes  No  If "yes", please explain \_\_\_\_\_

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**Anxiety**

39. What problems does your youngster have with fears and anxiety?

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40. Are there situations or activities he or she avoids because of anxiety or fear of not doing well?

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41. In what ways do stress or anxiety cause physical complaints?

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42. Has your child ever suffered a trauma and does he or she continue to show fear or avoidance when reminded of any of these events or being in similar situations? Yes  No  ~~Yes~~ ~~No~~ ~~Yes~~ ~~No~~ if yes, please describe

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43. Does he or she have obsessive worries or compulsive behaviors?

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44. What problems does he or she have with muscle or verbal tics? These are repetitive movements such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming.

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## Alcohol and drug use

45. Has your child tried smoking cigarettes? Yes  No

46. Do you have any knowledge or suspicion that your child has had alcohol without your permission? If so describe.

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47. Do you have any knowledge or suspicion that your child has used drugs?

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## Other Problems

48. Does he or she have problems with social awareness such as not being aware of how another person might be feeling, recognizing unstated rules of what is appropriate” or understanding body language or tone of expression?

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49. Is their speaking style “odd” (too exact, unusual tone or too formal)? Does he or she have problems with the rules of conversation? Does he or she have problems knowing when the listener has lost interest?

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50. Does he or she become overly fascinated by one particular topic or interest such that it becomes all-consuming?

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51. Does he or she become upset by changes in routine or have problems shifting from one activity to another?

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52. Does he or she have problems with being either under or overly sensitive to the feel of clothing or to being touched or is he or she both over and under sensitive to pain?

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53. Does he or she have problems with being overly sensitive to sounds or noise?

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54. Does he or she have problems with being overly sensitive to smells or tastes? Is he or she a very picky eater?

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55. Does he or she have problems with being especially sensitive to light or glare? Does he or she complain of room lights being too bright? \_\_\_\_\_

**Other health related behaviors**

56. Is there anything unusual about your child's diet or eating? \_\_\_\_\_

57. How much activity or physical exercise does he or she get? \_\_\_\_\_

58. Please check any of the following sleep problems your youngster experiences:

- |   |                            |                |
|---|----------------------------|----------------|
| Difficulty falling asleep because mind too active | Restless sleep             | Sleep walking  |
| Delays going to bed                               | Sleeps unusual hours       | Teeth grinding |
| Difficulty waking                                 | Nightmares or vivid dreams | Snoring        |
| Frequent waking,                                  | Sleeping too much          | Bedwetting     |
|   | Fearful to sleep alone     | Sleep Apnea    |

**Family History**

59. Put the letter symbol in the appropriate spaces.

**Parents (M=Mother, F=Father)** (History unknown \_\_\_\_\_)

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|------------------------|-----------------|-------------------|
| ADD (distractible)     | Suspected _____ | Treated for _____ |
| ADHD (hyper/impulsive) | Suspected _____ | Treated for _____ |
| Anxiety                | Suspected _____ | Treated for _____ |
| Depression             | Suspected _____ | Treated for _____ |
| Alcohol problems       | Suspected _____ | Treated for _____ |
| Drug problems          | Suspected _____ | Treated for _____ |

**Siblings (B=Brothers, S=Sisters)** (History unknown \_\_\_\_\_)

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|------------------------|-----------------|-------------------|
| ADD (distractible)     | Suspected _____ | Treated for _____ |
| ADHD (hyper/impulsive) | Suspected _____ | Treated for _____ |
| Anxiety                | Suspected _____ | Treated for _____ |
| Depression             | Suspected _____ | Treated for _____ |
| Alcohol problems       | Suspected _____ | Treated for _____ |
| Drug problems          | Suspected _____ | Treated for _____ |

**Grandparents (M = Mother's parents, F = Father's parents)** (History unknown \_\_\_\_\_)

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|------------------------|-----------------|-------------------|
| ADD (distractible)     | Suspected _____ | Treated for _____ |
| ADHD (hyper/impulsive) | Suspected _____ | Treated for _____ |
| Anxiety                | Suspected _____ | Treated for _____ |
| Depression             | Suspected _____ | Treated for _____ |
| Alcohol problems       | Suspected _____ | Treated for _____ |
| Drug problems          | Suspected _____ | Treated for _____ |