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Child & Adolescent Intake Questionnaire

Child's Name:	Today's Date:
Date of Birth:	Age:

Mother's Name:
Father's Name:

Referred By:

What Are Your Concerns About Your Child?
When Did You Begin To Notice These Concerns?

Past Psychiatric History

Has your child ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

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Has your child ever seen a psychologist? ___

Has your child ever seen a therapist?

Has your child ever been hospitalized for psychiatric reasons? If so, where and when?

Has any professional ever diagnosed your child's behavior? If so, who, what diagnosis did they give and when?

Please check the behaviors below that pertain to your child.

Nervous	Hyperactive	Temper tantrums	Poor sleep
Short attention span	Cries easily	Behavior problems	Destroys property
Easily frustrated	Excessive fears	Motor tics	Bite nails
Pulls hair	Frequent headaches	Frequent stomachaches	Fatigue/easily tired
Harms self (ie. cutting)	Hurts others (hits, bites, kicks)	Overweight	Perfectionist
Shy	Does not follow rules	Worries a lot	Overly talkative
Low self esteem	Likes self	Withdrawn/sullen	Slow learner
Demands attention	Plays well with peers	Irritable	Trouble making friends
Prefers to play alone	Depressed/sad	Legal problems	Weird ideas/bizarre thoughts
Running away from home	Vision problems	Hearing problems	Speech problems
Sexually active	Alcohol use	Drug use	Tobacco use
Legal Problems	Head Injury	Suicidal statements	Suicidal Attempts

Current Medications: Please list all medications taken by your child.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*

1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medication History: Please list all medications that have been taken by your child.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*	**Reason for Discontinuation**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Family/Social History:
Who lives in the child's home?____
Does the child have a second home where they spend part of the week?_____________________
Are parents married/partnered/separated/divorced?__________________________________
How long have parents been married (*if applicable*)?_______________________________

Siblings					
Name	DOB & Age	Relationship *(full,1/2,step,etc)*	Grade	Medical Problems?	Psychiatric Problems?

Family History: Please indicate if there is a family history of the following conditions and who is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Educational History:

Current School:	County/School District:
Grade:	Type of Class: *Regular, Inclusion, Self-Contained, intensive,etc?*
Does your child have an IEP or 504 Plan? If yes, what is the exceptionality (diagnosis) that qualified him/her for the IEP/504 Plan?	Is your child in Exceptional Student Education (ESE)?

Has your child ever been suspended or expelled from school?	What are your child's grades this year, thus far?

Legal History:

Arrest(s):	Date(s):

Substance Abuse History *please include age of first use and frequency if known*:

Does your child use illegal substances?

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____
____
____

Any other issues not yet addressed? ____
____
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