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Child Intake/History Questionnaire

Child's Name: _____ Birthdate: _____

Your Name: _____ Today's Date: _____

What are you hoping to accomplish through my services? _____
_____
_____
_____

Has your child ever had a previous psychological evaluation? YES_____ NO _____
If so, when and where? _____
For what reason? _____

Family History

Father's Name: _____ Age: _____

Mother's Name: _____ Age: _____

Relevant Phone Numbers (name, relationship, number):_____
_____
_____

Parents' current marital status: _____
Who has legal custody of child? _____

List all others living in the home with your child

Name	Age	Relationship to child

Has your child ever been placed in a foster home, group home or shelter? _____
If so, please describe setting: _____

Has there ever been any DPS involvement?: _____
If so, please describe: _____
_____
_____

Please describe the type of discipline used in your household: _____
_____
_____

Describe parent-child (or caregiver-child) relationship: _____
_____

Has your child ever experienced verbal, physical, or sexual abuse? Neglect? If so, please explain:
_____
_____
_____

I am interested in whether anyone in your family has had any of the following conditions.
Please put an X in the appropriate columns.

	Child's Mother	Child's Father	Child's Sister	Child's Brother	Child's Grandfather	Child's Grandmother	Other: (Specify)
Hyperactive as child							
Repeated grade							
Speech problems							
Seizures							
Mental Retardation							
Autism, Asperger's, PDD							
OCD							
Tourette's, Tic Disorder							
Behavioral problems							
Learning disability							
Trouble with law							
Depression							
Eating problems							
Anxiety							
Schizophrenia							
Emotional problems							
Drinking issues							
Drug problems							
Serious health issues							
Social/shyness issues							
Genetic Disorder							
Suicide Attempt							

Medical History

Child's birth weight: _____ Length of pregnancy: _____

Were there any medical problems during pregnancy or birth? YES_____ NO _____

If so, what were they?_____

Were there any medical problems during the 1st year of your child's life? YES_____ NO_____

If so, please describe: _____
_____

Does your child have a history of any of the following? (Please mark X next to those that apply)

Hospitalization	_____	Problems walking	_____
Head Injury	_____	Dental issues	_____
Seizure	_____	Allergies	_____
Poisoned	_____	Asthma	_____
Sleep disturbance	_____	Vision problems	_____
Many ear infections	_____	Hearing problems	_____
Sensory Issues	_____	Weight issues	_____
Poor coordination	_____	Speech issues	_____
Eating problems	_____	Stomach problems	_____
Special diet	_____	Problems with toileting	_____
Problems with ADL's (dressing, hygiene)	_____	Problems with bed wetting	_____

Developmental Milestones

Please list the approximate age that your child first did the following activities:

	Approximate Age	Not Yet	Don't Remember
Walked without help			
Spoke 1st words other than mama/dada			
2-3 word sentences			
Toilet trained - day			
Toilet trained - night			
Rode bike without training wheels			
Tied own shoes			

Has your child ever experienced a regression in his/her development (e.g., was talking then stopped)? YES _____ NO_____
If yes, please describe: _____
_____
_____

Has your child entered into puberty? YES_____ NO_____

If so, please describe any difficulties (sexualized behaviors, inappropriate touching, other concerns):_____
_____
_____

Communication Style

I am interested in how your child communicates including ways other than words. Please X appropriate boxes.

Crying	_____	Pictures/Symbols	_____	Other devices	_____
Signs	_____	Single words	_____	(Please list):	_____
Gestures	_____	Sentences	_____		

If your child uses a visual schedule, please describe: _____
_____
_____

Medical Status

Current health status (excellent, good, poor):_____

Significant past illnesses: _____
_____

Is your child currently being treated for any illness? If so, please describe: _____
_____

Physical health problems that your child complains of: _____
_____

Medications that your child is currently taking (dosage, frequency, length on medication): ____
_____
_____
_____

Child's physician: _____ Child's Psychiatrist: _____

Has there been a change in your child's weight, appetite or sleep in the **past 6 months**? If so, please describe:_____
_____
_____

Has your child ever received any professional mental health treatment? YES _____ NO _____
If so, please describe (when, where, for what reason, was it helpful):_____
_____
_____
_____

Educational History

School: _____ Grade:_____

District: _____ Teacher: _____

Reading Grade Level: _____ Spelling Grade Level: _____ Math Grade Level: _____

Has your child ever repeated a grade? _____

What grades does your child typically receive? _____

Does your child receive any special education services? If so, please describe: _____
_____
_____

Does your child exhibit any behavioral problems in school? Does the teacher report other difficulties? _____
_____

Attendance problems: YES _____ NO _____ Homework problems: YES _____ NO_____

Is your child involved in any sports, youth groups, clubs, etc.? If so, please explain: _____
_____
_____
_____

Concerns

What are your primary concerns regarding your child? _____
_____
_____

How serious do you think your child's problems are at this time? _____

Have you taken steps to address these concerns? If yes, please describe: _____
_____
_____
_____

What strategies, if any, have been helpful?

- o Time outs
- o Ignoring
- o Redirecting
- o Distracting
- o Consequences
- o Tokens
- o Praise
- o Visual Aids
- o Physical Prompts

Does your child exhibit any repetitive behaviors? YES _____ NO _____
If so, please describe: _____
_____
_____

What have you been told by doctors, teachers, or others about your child's difficulties? _____
_____
_____
_____

What are some positive qualities of your child? _____
_____
_____
_____

Please list any traumatic events that you think may have impacted your child including deaths, parental divorce, significant illness, birth of a sibling, moves, change in school, weather disaster, etc.

Incident	Child's Age	Comments
_____	_____	_____
		_____
_____	_____	_____
		_____
_____	_____	_____
		_____
_____	_____	_____
		_____
_____	_____	_____
		_____

Below are some behaviors that I feel are important to know about. Please mark X in the appropriate column for each behavior.

Behavioral Area	**No Problems**	**Some Problems**	**Serious Problems**
Fear and worries			
Clingy, dependent			
Temper Tantrums			
Many physical complaints			
Social immaturity			
Nervous twitches or tics			
Unhappy child			
Angry child			
Brags			
Problems with friends			
Alcohol/drug use			
Fights with siblings			
Act without thinking			
Hyperactive			
Short attention span			
Stealing			
Lying			
Perfectionistic			
Disobeying			
Arguing			
Whines/cries			
Suicidal thoughts or talk			
Isolated			
Lacks energy			
Strange ideas			
Strange behaviors			
Other (specify):			

Does your family participate in religious activities? If so, please describe anything you would like me to know about your religious beliefs or involvement: _____
_____

Does your child identify with a particular cultural or ethnic group? If so, please describe what this identification means to your child and/or to your family: _____
_____