INTAKE QUESTIONNAIRE - YOUTH

Client's Name: _____ Date of Birth: _____

Name of person completing this form: _____

Relationship to Client: _____ Today's Date: _____

The questions below will provide your therapist with some initial information about your child and family. The questionnaire asks about many different parts of your child's life. Depending on your child's age and your family situation, not all of the questions will apply. Just answer as best you can. Many questions are personal and you may not be comfortable answering them before you have met your therapist. That is okay – please feel free to skip any questions you are uncomfortable answering.

FAMILY BACKGROUND

- Please describe your child's current living situation, including the names and ages of everyone in the home, and any visitation/contact with parents or significant caregivers who do not live in the home.

- Is your child adopted?
  - ☐ Yes – age at adoption: _____
  - ☐ No

- Please tell us about any cultural, spiritual, or religious beliefs or practices that are important to your child and/or family.

SCHOOL

- Name of current school: _____ Grade: _____

- Please check any or all that apply:
    - ☐ I am concerned about my child's learning
    - ☐ I am concerned about my child's behavior at school
    - ☐ I don't have any concerns about how my child is doing at school

- Which of the following best describes your child's school arrangement? (mark all that apply)
    - ☐ My child has an IEP – Reason: _____
    - ☐ My child has a 504 Plan
    - ☐ My child attends an Alternative School
    - ☐ My child receives other emotional or academic supports
    - ☐ My child does not receive any special services

DEVELOPMENT

- Please describe any concerns about your child's development. For instance: Was your child delayed in meeting any important milestones, such as starting to talk or walk? Has your pediatrician ever expressed concerns about how your child is developing? Are you concerned about your child's development?

- Has your child ever received any of the following?
    - ☐ Early Intervention 0-3
    - ☐ Services through the local Intermediate Unit (e.g., CAIU)
    - ☐ Speech therapy
    - ☐ Occupational therapy
    - ☐ Physical therapy

PHYSICAL HEALTH

- Name of pediatrician or family doctor: _____

  Address: _____

  Phone: _____

- Is your child currently on any medications?
    - ☐ No
    - ☐ Yes – please list medication, dose, and reason taken:

- Do you have any concerns about your child's appetite or eating habits? For instance, over or undereating, extreme pickiness, etc.?
    - ☐ No
    - ☐ Yes – please describe:

- Has your child ever had any of the following medical issues?
    - ☐ Asthma
    - ☐ Allergies to: _____
    - ☐ Broken bones
    - ☐ Diabetes
    - ☐ Frequent ear infections and/or tubes in ears
    - ☐ High lead levels (now or in past)
    - ☐ Hearing loss / hearing difficulty
    - ☐ Head injury or concussion
    - ☐ Hospitalization – Date and reason: _____
    - ☐ Seizures
    - ☐ Stitches
    - ☐ Surgery – Date and reason: _____
    - ☐ Vision difficulty
    - ☐ Other medical condition:_____

- To your knowledge, is your child sexually active?
    - ☐ No
    - ☐ Yes
    - ☐ I'm not sure

MENTAL HEALTH

- Has your child ever been in counseling or received mental health services of any kind?
  - ☐ No
  - ☐ Yes – please describe (dates, name of provider, type of service):

- Has your child ever taken medication for behavior or emotional reasons?
  - ☐ No
  - ☐ Yes – please describe (medication, reason, and who prescribed it)

- Has your child been diagnosed with a developmental or mental health condition? For example, autism spectrum disorder, anxiety, ADHD, etc.
  - ☐ No
  - ☐ I'm not sure
  - ☐ Yes – please list diagnoses and who made the diagnosis:

- Has your child ever expressed any suicidal thoughts, attempted suicide, or engaged in self-harm (e.g., cutting)?
  - ☐ No
  - ☐ Yes
  - ☐ I'm not sure

- To your knowledge, has your child ever experimented with drugs and alcohol, or taken prescription drugs "for fun"?
  - ☐ No
  - ☐ Yes
  - ☐ I'm not sure

- Has your child ever been hospitalized for mental health reasons?
  - ☐ No
  - ☐ Yes – please provide dates and reason(s):

- Has your child ever been involved with any of the following?
  - ☐ In trouble with the law or police
  - ☐ Juvenile Probation Services
  - ☐ Mental Health Case Management Services
  - ☐ Student Assistance Program (through school)
  - ☐ School counselor (group or individual counseling at school)

- Mental health issues affect many families. Please check the box if your child has close family members or relatives with any of the following issues. On the line, indicate the person's relationship to your child (e.g., parent, sibling, aunt).
  - ☐ Depression or frequent sadness _____
  - ☐ Anxiety, nervousness, worrying a lot _____
  - ☐ Bipolar disorder_____
  - ☐ Problems with anger management, violence, or aggression _____
  - ☐ Posttraumatic stress_____
  - ☐ Eating disorder (anorexia, bulimia) _____
  - ☐ Attention-Deficit/Hyperactivity Disorder (ADHD/ADD) _____
  - ☐ Learning disability _____
  - ☐ Intellectual or developmental delays _____
  - ☐ Autism spectrum disorder / Aspergers_____
  - ☐ Hallucinations or delusions, psychosis, schizophrenia_____
  - ☐ Drinking too much or using drugs _____
  - ☐ Other _____
  - ☐ None that I am aware of

DAILY LIVING / ROUTINE

- How much "screen-time" does your child have on a typical day? Screen-time includes time on a tablet or smart phone, playing computer or video games, and watching TV or movies. (Don't count time your child spends on a computer or the internet for school purposes, like researching a paper or doing homework.) _____ hours per day

- Is your child involved with any school or community activities, clubs, or teams? If so, please list below.

- Please describe your child's sleep routine (bedtime, wake time, where he/she sleeps).

- How well does your child sleep? Please select all that apply.
  - ☐ Has difficulty falling asleep
  - ☐ Has difficulty staying asleep / wakes up in middle of the night
  - ☐ Sleep walks / sleep talks
  - ☐ Has frequent nightmares or night terrors
  - ☐ Sleeps well, no concerns

OTHER INFORMATION

- Has Children & Youth Services (child welfare) ever been involved with your child or your family, for any reason?
  - ☐ No
  - ☐ Yes, in the past
  - ☐ Yes, CYS is currently involved

- Please describe any stressful life events that your child or family has experienced. Examples might include separation or divorce; a major illness, injury, or death in the family; abuse or neglect; foster care; homelessness; a family member's mental health or substance use issues; or any other stressful situation.

- Is there anything else you would like your child's therapist to know before you meet?

Thank you for taking the time to complete this questionnaire.