YOUTH INTAKE QUESTIONNAIRE – CAMPBELL PSYCHOLOGICAL SERVICES

Client's Name: _____ Date of Birth: _____

Name of person completing this form: _____

Relationship to Client: _____ Today's Date: _____

The questions below will provide your child's evaluator with some initial information about your child and family. This will help us to streamline the assessment by focusing what we talk about. The more information we have beforehand, the more we can focus on the most important issues when we meet.

The questionnaire asks about many different parts of your child's life. Depending on your child's age and your family situation, not all 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 child's evaluator. 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

- If your child has parents or siblings who do not live in the home, please describe the visitation arrangement or how often they have contact.

- 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

- Has your child ever repeated a grade?
  - ☐ Yes – which grade? _____
  - ☐ No

- During the current or most recent school year, did your child fail any classes?
  - ☐ Yes – how many classes? _____
  - ☐ No

- Has your child ever been suspended or expelled from school?
  - ☐ Yes – reason: _____
  - ☐ No

EARLY CHILDHOOD

- Please describe any concerns you had about your child's development. For instance: Was your child delayed in meeting any important milestones, such as starting to talk or walk? Did your child's doctor ever express concerns about how your child was developing?

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

PHYSICAL HEALTH

- Name of pediatrician or family doctor: _____

  Address: _____

  Phone: _____

- Is your child now or has he/she in the past been on medication for emotional or behavioral problems, including ADHD?
  - ☐ No, my child has never been on medication
  - ☐ Yes, my child is <u>currently</u> on medication
  - ☐ Yes, my child has been on medication <u>in the past</u> but not at this time

  If your child is currently on medication, please list medication name, dosage, and who prescribes it:

  If your child was previously on medication, please list medication name and who prescribed it:

- 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
  - ☐ Frequent headaches or migraines
  - ☐ 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:_____

- If you have any concerns about your child's physical health, not listed above, please describe:

- During pregnancy, did this child's mother use any of the following?
  - ☐ Cigarettes – how many per day? _____
  - ☐ Alcohol – how often? _____
  - ☐ Marijuana – how often? _____
  - ☐ Other drugs – type of drug? _____
  - ☐ None of the above

- Were there any complications with pregnancy, labor, or delivery?

- Did your child have any health issues or feeding issues as an infant?

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

MENTAL HEALTH

- Has your child ever received any of the following mental health services:
  - ☐ Outpatient therapy or counseling
  - ☐ Psychological evaluation or testing
  - ☐ Medication / psychiatrist
  - ☐ BHRS (i.e., BSC, TSS, Mobile Therapy)
  - ☐ Family-Based Mental Health Services (in-home)
  - ☐ Other in-home counseling or therapy services
  - ☐ Partial hospitalization
  - ☐ Inpatient hospitalization
  - ☐ Residential treatment

If you checked any of the boxes above, please list the dates, provider/agency, and reason.

- 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

  If you marked "yes," please tell us more about your child's drug or alcohol use:

- 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).

Anxiety

- ☐ Excessive worry or fearfulness_____
- ☐ Obsessions, OCD _____
- ☐ Panic attacks _____
- ☐ Social anxiety _____

Developmental/Neurological

- ☐ Attention problems, hyperactivity, ADHD_____
- ☐ Autism spectrum disorder/Aspergers _____
- ☐ Intellectual delays _____
- ☐ Learning problems / Learning disability _____
- ☐ Tic disorder/Tourette's _____

Mood Problems

- ☐ Anger issues _____
- ☐ Bipolar Disorder _____
- ☐ Depression _____

Substance Abuse

- ☐ Abuse of street drugs or prescription medicines_____
- ☐ Alcohol abuse / heavy drinking _____

Other

- ☐ Antisocial behavior (e.g., stealing, fighting, criminal behavior) _____
- ☐ Eating disorder (anorexia, bulimia, binge-eating) _____
- ☐ Delusions or hallucinations _____
- ☐ Posttraumatic Stress Disorder _____
- ☐ Paranoia, overly suspicious _____
- ☐ Suicide _____
- ☐ Schizophrenia _____

DAILY LIVING / ROUTINE

- 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
  - ☐ Sleepwalks / 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 – reason: _____
  - ☐ Yes, CYS is currently involved – reason: _____

- Has your child ever been placed in foster care?
  - ☐ No
  - ☐ Yes – dates: _____

- Please describe any other 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; homelessness; a family member's mental health or substance use issues; or any other stressful situation.

- Is there anything else you would like to share?

Thank you for taking the time to complete this questionnaire