Innervisions Counseling & Consulting Center S.C.

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INTAKE QUESTIONNAIRE – CHILD

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: _____ Date: _____

Child is (circle one): my biological child my adopted child my foster child Other: _____

IDENTIFYING INFORMATION (for individual receiving services)

Child's Name: _____ Date of Birth: _____

Address: _____ Sex: _____

_____ Cell Phone (indicate whose #): _____

Home Phone: ( ) _____ ( ) _____

Social Security Number: _____ Household Income: $ _____

Preferred Pronouns: He/His/Him or She/Hers/Her

Who referred you to Innervisions? _____

Child's Race:

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Child's Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Child's Language of Choice:

- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: _____

Family's Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: _____

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: _____
If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: _____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

a. Behavior at home	g. Overactivity	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Relationship
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior at school	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. School performance	r. Other (explain):

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2. How long has the child had this/these problem(s)? _____

3. Has the child received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

   If yes when, where and with whom? _____

SUICIDE RISK

Suicide risk: □ Denies □ Ideation □ Intent □ Plan □ Attempt
Notes:

Danger to others: □ Denies □ Ideation □ Intent □ Plan □ Attempt
Notes:

Past History of Suicide Risk: _____
_____
_____

Current/Recent Suicide Risk:_____
_____
_____

FAMILY HISTORY

1. With whom does the child currently live (names and relationship)? _____

   Has the child lived with anyone else in the past? ☐ Yes ☐ No With whom? _____

2. Please provide the following information about the child (as applicable):

Father's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

Mother's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

Stepfather's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

Stepmother's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

Foster Father's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

Foster Mother's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

Guardian/Other's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Education: _____

3. Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (full, half, step, foster)	Lives with Child?	If no, lives where?
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	

4. Does the child or any other family member have a history of alcohol or drug problems? ☐ Yes ☐ No

If yes, please explain: _____

_____

5. Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? ☐ Yes ☐ No If yes, please describe the circumstances: _____

_____

_____

_____

_____

LEGAL HISTORY

Please describe any involvement the child has had with the legal system (arrests, convictions, probation, parole):

_____

_____

DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal? ☐ Yes ☐ No ☐ I don't know

If no, please explain: _____

2. Did mother use alcohol or other drugs during pregnancy? ☐ Yes ☐ No ☐ I don't know

If yes, please explain: _____

3. Please list any medications taken during pregnancy: _____

4. Did the child reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained - night				

MEDICAL HISTORY

1. Primary Care physician/pediatrician: _____

2. Would you like Innervisions to coordinate care with your PCP? ☐ Yes ☐ No
If yes, you will need to fill out a release of information for your PCP.

3. Please check the appropriate box if the child has experienced any of these problems:

☐ Eye disease, injury, poor vision
☐ Ear disease, injury, poor hearing
☐ Nose, sinus, mouth, throat problems
☐ Head injury
☐ Convulsions or seizures
☐ Memory problems
☐ Extreme tiredness or weakness
☐ Thyroid disease or goiter
☐ Skin disease
☐ Heart disease
☐ Back, arm, leg or joint problems
☐ Blood disease
☐ Stomach problems
☐ Premenstrual Syndrome (PMS)
☐ Eating disorder
☐ Liver, gallbladder disease
☐ Cancer
☐ Bowel problems
☐ Hemorrhoids, rectal bleeding
☐ Loss of consciousness
☐ Frequent or severe headaches
☐ Sleep disturbances
☐ Neck stiffness, pain, swelling
☐ Marked weight changes
☐ Circulatory problems
☐ Allergies or asthma
☐ Diabetes
☐ Encephalitis
☐ Meningitis
☐ Pregnancy
☐ High blood pressure
☐ Other

Please explain anything checked above: _____

_____

3. Please provide information about medication(s), prescription or over-the-counter, which the child takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): _____

_____

SCHOOL INFORMATION

1. What school does the child currently attend? _____
2. What is the child's teacher's name? _____
3. What grade is the child in? _____
4. How many schools has the child attended? _____
   In which cities/towns were they located? _____
5. Does the child have a written IEP? ☐ Yes ☐ No
   Is the child in special education classes? ☐ Yes ☐ No Type: _____
6. Is the child experiencing any problems in school?
   Academics (grades): ☐ Yes ☐ No
   Behavior: ☐ Yes ☐ No
   Social (peers or adults): ☐ Yes ☐ No

   Please explain any "yes" responses: _____

   _____

SOCIAL RELATIONSHIPS / FRIENDS

1. How does the child get along with peers? _____

   _____

   _____

2. How does the child get along with adults? _____

   _____

_____

3. Does the child spend more time with (check the closest answer):

☐ Same age children ☐ Adults

☐ Older children ☐ Mostly alone

☐ Younger children

4. What are the child's hobbies and interests? _____

_____

_____

HOME LIFE

1. Is there a behavior problem at home? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

2. What are the child's strengths? _____

_____

3. What are the family's strengths? _____

_____

4. What are the child's weaknesses? _____

_____

5. What are the family's weaknesses? _____

_____

6. What kind of discipline is used with the child? _____

Who is the primary disciplinarian? _____

7. Are there any family circumstances you would like us to be aware of? _____

_____

8. What goals would you like to see reached as a result of your child's involvement with Innervisions Counseling?

_____

_____

_____

_____

9. How will you know when these goals have been reached (describe changes in behavior or functioning)?

_____

_____

_____

_____

THERAPIST REVIEW

Signature: _____ Date: _____