Connections Counseling, LLC

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Child Intake Questionnaire

(use additional paper if needed)

Date:______________________ Client ID: _______

Client's Name: ____

Person completing this form:_________________________ Relationship to client: ____________________

Why are you seeking treatment at this time for your child?

____

____

When did this start? _______________________________

Is there anything that you've noticed that improves this situation? Makes it worse?

____

____

____

____

Briefly describe how this child's behavior affects the family, school performance or social interactions:

____

____

____

What are you hoping this child will gain from therapy?

____

____

____

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What are you hoping the family will gain from therapy?

____

____

____

What strengths does this child have?

____

____

Any other comments or concerns?

____

____

____

Name of child's biological father:_________________________________ Date of Birth:____________

Occupation/Place of Employment:________________________________

Name of child's biological mother:________________________________ Date of Birth:____________

Occupation/Place of Employment:________________________________

Who has legal custody of this child? _______________________________

Does your child have an OCS Worker or Juvenile Probation Officer? ________________

If yes, what is/are their name(s)? ____

Siblings:

Name	Age	Biological, Step, Half	Quality of Relationship

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Who lives with this child?

Name	Age	Type of Relationship	Quality of Relationship

Other people who have regular contact with this child: (e.g boyfriend/girlfriend, aunt/uncle, neighbor, etc.)

Name	Age	Type of Relationship	Quality of Relationship

Who is the primary caregiver for this child? ____

Is this child involved in any legal or court proceedings, including criminal and custody?

____

____

Health History

Does the child have a medical provider? Yes No

Medical Provider's Name? ____

Date of last physical exam:______________________

Any medical concerns or disabilities? Yes No

If yes, please describe: ____

____

Medications child is currently taking: ____

____

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Has the child had previous counseling, including residential treatment? Yes No

Please describe:

____

____

____

____

Does the child have a history of self-harm or suicide? Yes No

If yes, when was the last incident? ____

Is there a family history of self-harm or suicide? Yes No

Is there a family history of mental illness or developmental delays? Yes No

If yes, please list relationships to child and illness and/or delays:

____

____

Has the child seen alcohol or illegal/ prescription drug use? If yes, please describe:

____

____

Has the child been given or used substances or alcohol? Yes No

If yes, please describe: ____

Is there a family history of substance or alcohol use/abuse? Yes No

If yes, please describe:

____

____

Education and Social History

Name of School:______________________________________ Grade:________________

Child is doing: Well Average Poorly

Does the child receive Special Education or have an IEP or 504?___________________________

Is there a history of referrals, detentions or suspensions? Yes No

If yes, please describe:____

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Please list any other academic and/or behavior problems the child has in school:

____

____

Please list any activities or programs that the child is involved in:

____

____

Does the child make friends easily? ____

Any concerns with social connections or behaviors?

____

____

Developmental History

Was the pregnancy planned? Yes No

Did child's mother use substances or alcohol during pregnancy? Yes No

Please list any complications or concerns during pregnancy or delivery:

____

____

Age child talked:_________ Age child walked :_________ Age child potty trained: ____________

Did child meet developmental milestones? Yes No

Any developmental concerns? ____

How many caregivers did the child have during infancy/toddler years? 1-2 3-4 5 or more

Describe any attachment concerns:

____

____

How many times has this child moved? ______________

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Trauma History

Have there been any prior concerns of physical abuse, sexual abuse and/or neglect to this child or siblings?

Yes No

If yes, please give dates and briefly describe:

____

____

____

____

Has the child witnessed violence or fighting? Yes No

If yes, please provide some information:

____

____

Please list other possible traumas (e.g. car accidents, grief and loss, etc.):

____

____

Has this child seen adults hit one another? Yes No

If yes, please describe: ____

To your knowledge, has anyone in the immediate family ever been sexually abused? Yes No

If yes, please provide some information:

____

____

To your knowledge, has anyone in the immediate family ever been physically abused? Yes No

If yes, please provide some information:

____

____

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Brief Checklist

Does this child have any of the following behaviors? Please indicate past (P) or current (C) or both as appropriate.

Sleep problems: nightmares, insomnia, sleepwalking	Often	Occasionally	Never
Fear of people, places, animals, situations			
Sense of fearlessness			
Aggressiveness, hitting, bullying			
Destroying property, fire setting			
Sexualized play, behavior, language, masturbation			
Inappropriateness with other people's private or social spaces			
Withdrawal, Isolating self			
Lying			
Making up things, but not knowing it isn't true			
Stealing or taking things			
Anger, tantrums, foul language, cruelty to animals			
Sadness, tearfulness, clinginess			
Nervous habits: nail biting, picking skin, etc.			
Pulling at hair or eyelashes			
Eating disorders: overeating, refusing to eat, vomiting, hoarding food			
Mood changes			
School problems			
Truancy (skipping school)			
Problems changing activities, places or things (resistant to change)			
Stares into space or seems preoccupied			
Gang affiliation			
Self-mutilation: cutting, marking, picking at skin, biting self			
Suicide attempts			
Talking about or trying to harm self or others			