

## CHILD INTAKE QUESTIONNAIRE

### CLIENT INFORMATION:

Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Numbers (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Can messages be left at day number? \_\_\_\_\_ Can messages be left at evening number? \_\_\_\_\_

Parent(s)/Guardian(s) Names: \_\_\_\_\_

Parent(s)/Guardian(s)' Marital Status:

Single  Married  Committed Relationship  Separated  Divorced  Widowed

If parents are separated/divorced, please indicate who has custody of child:

\_\_\_\_\_

Referred by: Name \_\_\_\_\_

Address & Telephone \_\_\_\_\_

Family Physician: Name \_\_\_\_\_

Address & Telephone \_\_\_\_\_

Emergency Contact Person: Name \_\_\_\_\_ Address \_\_\_\_\_

Telephone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

\_\_\_\_\_

### CURRENT DIFFICULTY:

Please indicate the reason that you are seeking services for your child at this time. Describe the nature of your child's difficulties and any family difficulties, including how long they have been present: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check the severity of your child's difficulties:

mildly upsetting  moderately upsetting  severe  very severe  extremely severe

Have you consulted anyone about your child's difficulties? If so, please indicate name, title, address, and telephone number:

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Has your child ever received counselling/treatment/hospitalization for emotional difficulties? Yes \_\_\_ No \_\_\_ If yes, please describe when and reasons for previous treatment:

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Has your child ever received medication for emotional difficulties? Yes \_\_\_ No \_\_\_ If yes, please describe the name, how much, how frequently, and with what results:

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Check off all that currently apply to your child:

- |  |   |
|--|---|
| <input type="checkbox"/> family problems                   | <input type="checkbox"/> stress or burnout              |
| <input type="checkbox"/> behavioural problems              | <input type="checkbox"/> anger/frustration              |
| <input type="checkbox"/> friendship problems               | <input type="checkbox"/> easily agitated/annoyed        |
| <input type="checkbox"/> school performance problems       | <input type="checkbox"/> eating problems                |
| <input type="checkbox"/> irritability                      | <input type="checkbox"/> sleeping problems              |
| <input type="checkbox"/> withdrawn                         | <input type="checkbox"/> low energy/fatigue             |
| <input type="checkbox"/> fears/phobias                     | <input type="checkbox"/> physical illness               |
| <input type="checkbox"/> anxious thoughts/worries          | <input type="checkbox"/> mean to others                 |
| <input type="checkbox"/> nightmares                        | <input type="checkbox"/> disobedient                    |
| <input type="checkbox"/> low self-esteem                   | <input type="checkbox"/> lying                          |
| <input type="checkbox"/> shyness                           | <input type="checkbox"/> stealing                       |
| <input type="checkbox"/> loneliness                        | <input type="checkbox"/> trouble with the law           |
| <input type="checkbox"/> depression                        | <input type="checkbox"/> running away                   |
| <input type="checkbox"/> self-mutilation                   | <input type="checkbox"/> temper outbursts               |
| <input type="checkbox"/> suicidal thoughts                 | <input type="checkbox"/> alcohol/drug problems          |
| <input type="checkbox"/> daydreaming/distractable          | <input type="checkbox"/> traumatic issues               |
| <input type="checkbox"/> concentration problems            | <input type="checkbox"/> grief/losses                   |
| <input type="checkbox"/> hyperactive                       | <input type="checkbox"/> strange thoughts or behaviours |
| <input type="checkbox"/> excessive behaviours              | <input type="checkbox"/> Other problems:                |
| <input type="checkbox"/> difficulties controlling impulses | _____   |

What are major stresses that your child and family are facing at this time? \_\_\_\_\_

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What do you wish for your child to accomplish from therapy? \_\_\_\_\_

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What changes (e.g. feelings, behaviours, etc) would you like to see in your child? \_\_\_\_\_

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What changes would you like to see in your family? \_\_\_\_\_

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What changes would you like to see in yourself? \_\_\_\_\_

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**CHILD'S PERSONAL HISTORY:**

Please list any medical and/or health difficulties that your child is currently experiencing:

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Is your child taking any medication? If yes, please indicate the name, how much, how frequently, and with what results?

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Has your child ever been hospitalized? Yes \_\_\_ No \_\_\_

If yes, please explain: \_\_\_\_\_

Please list any family history of illness: \_\_\_\_\_

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Please list any family history of emotional difficulties: \_\_\_\_\_

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Does your child drink alcohol or use any other substance? Yes \_\_\_ No \_\_\_ Unsure \_\_\_

If yes or unsure, please indicate what kind of substance(s) your child uses:

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Has your child experienced any life events that were particularly distressing or traumatic for him/her? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

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How does your child generally cope with stressful or upsetting circumstances (e.g. distract him/herself, seek help, become emotional, keeps to him/herself)?

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What are current interests, activities, sports, or hobbies that your child enjoys? \_\_\_\_\_

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Please describe your child's strengths: \_\_\_\_\_

FAMILY INFORMATION:

Please describe who lives with your child. If your child lives in multiple residences, please describe living arrangements including who lives with your child at each residence:

\_\_\_\_\_  
\_\_\_\_\_

Please indicate number of moves in your child's life: \_\_\_\_\_

Marital History of Parents (please check all that apply):

Natural Parents:	<input type="checkbox"/> married	when: _____
	<input type="checkbox"/> separated	when: _____
	<input type="checkbox"/> divorced	when: _____
	<input type="checkbox"/> deceased M or F	when: _____
Stepparents:	<input type="checkbox"/> stepmother	when involved in child's life: _____
	<input type="checkbox"/> stepfather	when involved in child's life: _____
Other significant partner:	<input type="checkbox"/>	when involved in child's life: _____

If parents are separated/divorced:

How much contact does your child have with his/her natural mother? \_\_\_\_\_

How much contact does your child have with his/her natural father? \_\_\_\_\_

How many brothers and sisters does your child have? \_\_\_\_\_

Please list their gender and ages: \_\_\_\_\_

\_\_\_\_\_

Does your child have any step-siblings or half-siblings? Yes  No

If yes, please list their gender and ages: \_\_\_\_\_

\_\_\_\_\_

Please give a short description of your child's relationship with his/her siblings:

\_\_\_\_\_

\_\_\_\_\_

Please describe your relationship with your child including strengths and areas of concern:

\_\_\_\_\_

\_\_\_\_\_

Please describe your child's relationship with other caretakers including strengths and areas of concern: \_\_\_\_\_

\_\_\_\_\_

Briefly describe any significant past relationships your child may have had with others: \_\_\_\_\_

\_\_\_\_\_

## CHILD'S DEVELOPMENTAL HISTORY

### Prenatal & Birth History:

Length of Pregnancy: \_\_\_\_\_ Normal Pregnancy? Yes \_\_\_ No \_\_\_  
If mother was ill, upset, or experienced any pregnancy complications, please explain:

Length of active labour \_\_\_\_\_ hrs \_\_\_\_\_ Easy Labour \_\_\_\_\_ Difficult Labour \_\_\_\_\_

Type of Delivery: \_\_\_ spontaneous \_\_\_ cesarean \_\_\_ breech \_\_\_ with instruments

Child's Birth Weight: \_\_\_ lbs. \_\_\_ oz.

Did child experience any complications at birth? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

### Newborn/Toddler Period:

Did your child experience any of the following complications:

Irritability Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Vomiting Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Difficulty sleeping Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Colic Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Difficulty eating Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Difficulty gaining weight Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Convulsions/seizures Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Ear infections Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Difficulty attaching to others Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Separation anxiety Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

Other: \_\_\_\_\_ Yes \_\_\_ No \_\_\_ If yes, how long: \_\_\_\_\_

### Developmental Milestones:

Age at which your child:

Sat up \_\_\_\_\_

Crawled \_\_\_\_\_

Walked \_\_\_\_\_

Spoke single words \_\_\_\_\_

Spoke sentences \_\_\_\_\_

Toilet trained \_\_\_\_\_

Please indicate if there were any difficulties with developmental milestones: \_\_\_\_\_

Who generally disciplines your child: \_\_\_\_\_

What form of discipline do you use with your child (e.g. time-out, grounding, removal of privileges, yelling, spanking)? \_\_\_\_\_

Please describe how your child generally responds to discipline including any areas of difficulty: \_\_\_\_\_

CHILD'S EDUCATIONAL & OCCUPATIONAL HISTORY

Child's highest grade/level completed: \_\_\_\_\_

Has your child experienced any difficulties in school? Yes \_\_\_ No \_\_\_

If yes, please describe (e.g. academic, behavioural, social): \_\_\_\_\_

Does your child have any specific learning disabilities? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

Does your child attend school on a regular basis? Yes \_\_\_ No \_\_\_

Has your child ever been suspended or expelled? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

Please indicate the nature of your child's relationships with siblings and peers:

\_\_\_ individual play \_\_\_ group play \_\_\_ competitive \_\_\_ cooperative \_\_\_ leader \_\_\_ follower

Please describe the nature of your child's friendships (e.g. number and gender of friends, closeness of your child's relationships): \_\_\_\_\_

Please describe any difficulties your child has experienced with peers (e.g. fighting, frequent conflicts, few friends, victim of teasing or bullying): \_\_\_\_\_

Has your child ever been employed? Yes \_\_\_ No \_\_\_

If yes, please describe nature of your child's occupation and how long your child has been working there: \_\_\_\_\_

OTHER:

Please add any information not brought up by this questionnaire that may aid your psychologist in understanding and helping your child.

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