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:

_____

_____

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

_____

_____

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:

_____

_____

Check off all that currently apply to your child:

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___ withdrawn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

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

_____

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

_____

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

_____

_____

What changes would you like to see in your family? _____

_____

What changes would you like to see in yourself? _____

_____

CHILD'S PERSONAL HISTORY:

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

_____

_____

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

_____

_____

Has your child ever been hospitalized? Yes ___ No ____
If yes, please explain: _____

Please list any family history of illness: _____

_____

Please list any family history of emotional difficulties: _____

_____

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:

_____

Has your child experienced any life events that were particularly distressing or traumatic for him/her? Yes ___ No ____
If yes, please describe: _____

_____

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

_____

_____

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

_____

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:	___ married	when: _____
	___ separated	when: _____
	___ divorced	when: _____
	___ deceased M or F	when: _____
Stepparents:	___ stepmother	when involved in child's life: _____
	___ stepfather	when involved in child's life: _____
Other significant partner: ____		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.

_____
_____
_____
_____
_____