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CHILD CLINICAL INTAKE QUESTIONNAIRE

Please answer all of the questions on the following pages. The information you provide will become part of your confidential record with this office and will not be released to anyone without your written permission.

What is your child's?

Name ____________________ Date of birth __________

Age ________ Gender ________ Pediatrician ____________________

School ____________________ Grade __________

Teacher ______________ Principal ____________________

Who referred your child? ____________________

Name of parent/guardian completing this form ____________________

Your occupation ____________________

Your marital status ____________________

Name of spouse/partner ____________________

Occupation ____________________

Please describe your child's current family/living circumstances:

____

____

____

____

Name all people living with your child, their ages, and relationships to the child, beginning with yourself.

Name	Age	Relationship

Primary Concerns:

What is the primary reason for having your child seen at this time?

List the three behaviors or symptoms that concern you the most about your child. Start with the most troubling first and work your way down.

When did you first notice your child having these behaviors or symptoms?

What are you most worried might happen if things continue as they are?

Did your child ever have similar behavioral or emotional problems that concerned you when she/he was younger? If so, please describe these problems, when they occurred, and what was done about them.

Has your child ever seen another professional for help with behavioral or emotional problems? If so, please give the name of the professional and when they were seen:

____

Has your child ever been prescribed medicine to help with behavioral or emotional problems?

If yes, how long ago?

Please list the medicines he/she has taken in the past (not the current medication):

Name of medication	Dose (mg)	How many times per day

List any medical problems for which your child is currently being treated. Please indicate if a problem has been ongoing requiring regular or periodic care.

List any past hospitalizations your child has had for medical, surgical, chemical dependency, or psychiatric reasons.

List any medications to which your child is allergic or could not take due to intolerable side effects.

Please list all medications your child is **currently taking**. Include birth control, vitamins, and over the counter drugs. Please include the name of the prescribing doctor.

Name of medication	Dose (mg)	How many times per day	Prescribing doctor

FAMILY HISTORY:

Have any of your child's biological relatives on either parents' sides of the family had any of the following?

Condition or event	Which family member?
Nervousness or panic	
Depression	
Obsessive-compulsive problems	
Bipolar disorder (manic depressive illness)	
Suicide	
Alcohol or drug problems	
Police record (arrests, jail)	
Schizophrenia	
Mental retardation	
Developmental problems (autism, Asperger's)	
Learning disorder (dyslexia)	
Attention problems (AD/HD)	
Tourette's or other tic problems	
Other (describe)	

HISTORY OF BEHAVIORAL OR EMOTIONAL EVENTS AND PROBLEMS:

Please place a check in front of all that apply to your child:

☐ had to repeat a grade in school
If so, which grades has he/she repeated ______________________________

☐ was in at least one special education class or an SE curriculum

☐ has your child ever had psychological, psychoeducational, or IQ testing?

If so, where tested __________________ date of testing __________________

☐ was told by teacher or other professional your child has a learning disability

☐ has been in accelerated classes for smart kids

☐ has your child ever skipped a grade?

Does your child experience any of the following at school or at home (check all that apply):

☐ often leaves things unfinished

☐ is easily distracted

☐ has difficulty concentrating on reading or homework

☐ has difficulty sitting still

☐ feels restless or fidgety

☐ is impulsive; sometimes acts without thinking

☐ often misplaces or loses things

☐ is easily forgetful and needs frequent reminders

The following describe traits my child has or things my child has done (check all that apply):

☐ is unusually stubborn or self-willed

☐ has trouble conforming to rules/regulations

☐ tends to do the opposite of what he/she is told

☐ argues with you or his/her teacher

☐ loses her/his temper easily, sometimes breaks/throws things

☐ has shoplifted or stolen something

☐ has skipped school without permission or a legitimate reason

☐ has run away from home overnight

☐ often tells lies to deceive you or teacher

☐ has set fires, which were potentially dangerous

☐ has injured or killed a pet or small animal just for fun

☐ has broken or destroyed someone else's property (windows, cars, etc)

☐ has a reputation for starting fights

☐ has pulled a knife or gun on someone

☐ has tried to steal things by threatening someone

☐ has tried to force another person to engage in a sexual act

The following apply to my child:

☐ smokes cigarettes regularly

☐ has consumed beer, wine or other alcoholic beverages, recently or in the past

☐ has missed school (or was asked to leave) because of drinking

☐ has sniffed glue, gasoline, or fumes to get high

☐ has smoked marijuana (pot, weed, grass)

☐ has used amphetamines (crystal meth, ice, speed)

☐ has used cocaine (coke, crack, rocks)

☐ has used hallucinogens (LSD, PCP, peyote, mescaline)?

☐ has used heroin, opiates (junk, smack, horse, H)?

☐ has abused prescription medication (roxys, pain, sleep, ADD meds, etc.)

☐ has abused sedatives, tranquilizers (downers, bars, Xanax)?

☐ is regularly using some of the above substances now

Has your child ever had a period of time lasting two weeks or longer when she/he:

☐ seemed to be sad, depressed, moody, or irritable?

☐ didn’t feel much like eating or lost weight?

☐ felt like eating more than usual or gained extra weight?

☐ had trouble falling asleep or staying asleep?

☐ slept more than usual or had trouble waking up?

☐ withdrew from family and friends, talking less than usual?

☐ lost interest in things she/he usually liked to do?

☐ felt tired all the time but wasn’t physically sick?

☐ frequently complained of aches (headaches, stomachaches, etc.)?

☐ felt guilty over things she/he really wasn’t to blame for?

☐ felt worthless and thought she/he would be better off dead?

☐ couldn’t concentrate on work/school as well?

☐ talked about him/herself or some one else dying?

☐ thought a lot about death or dying?

☐ My child is feeling sad, blue, moody, or irritable now (check if yes).

☐ My child has experienced at least five of the items checked in this section continuously for the past two weeks or longer (check if yes).

Has your child ever had a period of time lasting at least one week when she/he:

☐ was so overly happy or "high" that she/he got into trouble?

☐ became more overactive than usual to the extent that it made others concerned?

☐ talked faster or more constantly than usual?

☐ said her/his thoughts were going very fast (racing) in her/his head?

☐ said that she/he had special powers to do remarkable things ?

☐ slept a lot less than usual without appearing or feeling tired?

☐ was unable to concentrate on things as usual?

☐ did extravagant things she/he later regretted (travel, spend money, sex)?

Please check the statements below that describe your child. My child:

☐ is an anxious person

☐ tends to worry a lot

☐ sometimes thinks too much about health concerns or illness

☐ worries about being away from his/her parents

☐ has complained about headaches or stomachaches before school

☐ worries that something will happen to him/her or to his/her parents

☐ needs to have a parent close to him/her to fall asleep

☐ has experienced an anxiety attack without apparent reason

If yes, how often do has he/she experienced these attacks?

____

During an anxiety attack my child (check all that apply):

☐ has trouble catching her/his breath

☐ his/her heart races too fast

☐ his/her face becomes flushed or hands begin to sweat

Please check all of the following that are true about your child:

☐ has seemed to have unusual and troublesome thoughts which he/she can't put out of his/her mind (getting hurt, germs, bugs, etc)

☐ has special habits or rituals that seem excessive or unnecessary (counting things, touching, hand washing, etc)

☐ checks and rechecks excessively on things already done, like turning off a light, or closing a door

☐ has wet the bed since age five

☐ has wet him/herself during the day since age five?

☐ continues to wet the bed now

☐ since he/she was potty trained, has he/she ever soiled on him/herself

☐ has continued to soil on him/herself now

☐ tends to get highly upset when things are not in their exact place

☐ thinks he or she is too fat

☐ has lost excessive weight intentionally

☐ exercises with the intent to lose weight?

☐ has lost more then ten pounds intentionally

☐ has gone on excessive eating binges

☐ has made him/herself vomit after binges or meals

☐ has tried diet pills or laxatives to lose weight

☐ has sudden, jerky movements, which are repetitive, like neck jerks, eye blinking, mouth twitches, shoulder shrugs?

☐ has a habit (now or in the past) of making repetitive sounds such as sniffs, grunts, throat clearing, barking, etc.

☐ has your child now or in the past had a habit of rocking his/her body or moving his/her fingers and hands in a repetitive way?

Has your child ever had beliefs that confused her/him such as (check the boxes that apply):

☐ thinking someone was out to get him/her?

☐ thinking that others could control his/her thoughts?

☐ hearing voices in his/her head that were telling him/her strange things?

☐ seeing visions that others can't see?

Check the box in front of each statement below that describes your child:

☐ my child is indifferent to or does not seem to like affection such as hugs, kisses, sitting close to you or others

☐ my child seems uninterested in or relates in a peculiar manner to other kids his/her age

☐ my child uses unusual or peculiar language with others

☐ my child seems more interested in things than in people

☐ my child sometimes displays repetitive movements such as hand or arm movements (flapping), clapping, twirling, etc.

☐ my child gets highly upset with even small changes in her/his routine or when things are out of place

☐ my child has habits of hurting herself/himself (biting, hitting, cutting)

Thank you for taking the time to answer these important questions. This information is helpful to the doctor/therapist in understanding your needs and how to best be of help to you and your child.