THE PSYCHOLOGY CENTER

PRE-INTAKE QUESTIONNAIRE FOR CHILDREN AGE 13 OR UNDER

Thank you for taking the time to complete this questionnaire before your first appointment. This allows us to address your presenting issues more quickly, without sacrificing the necessary gathering of background information that any clinician needs to render quality mental health care.

Name of Child: _____ **Date of Birth:** _____

Preferred name: ***(if different from first name)*** _____

Person completing form: _____

Relationship to child: _____

NOTE: If more space is needed for your answer(s), please use the back of the page, identifying which question is being answered.

1. PRESENTING PROBLEM(S)

a) For what problem(s) are you seeking help for your child at this time and for how long have these problems been ongoing?

_____

_____

_____

_____

_____

_____

b) Have there been any recent changes in your child's life, either at home or at school?

_____

_____

_____

2. DEVELOPMENTAL HISTORY

a) Were there any medical/obstetrical problems during pregnancy? ***If yes, please specify:***

_____

_____

b) Were there any complications during the delivery or soon after the birth? ***If yes, please specify, noting what treatment, if any, was given.***

_____

_____

c) At what age did your child:

Crawl? _____ Walk? _____

Speak words? _____ Sleep through night? _____

Dry all night? _____ Completely toilet trained? _____

d) Was there anything unusual about your child when they were younger?

_____

_____

e) Current school placement: _____ Grade: _____

School contact person(s) _____

f) Please describe any extended periods of separation or stressful times for your family and/or your child, recently, or in the distant past:

_____

_____

_____

3. FAMILY HISTORY:

Parent's name: _____ Age: _____

Educational level: _____Occupation: _____

Parent's name: _____Age: _____

Educational level: _____Occupation: _____

Parents' status: ☐ Married ☐ Never married ☐ Separated ☐ Divorced

Year married: _____ Year separated: _____ Year divorced: _____

If divorced, did either parent remarry or cohabit with another partner?

(note stepparent(s) name(s), year of remarriage, current status of subsequent marriage(s)

_____

_____

_____

Sibling(s) name(s) and age(s): _____

_____

Half-sibling(s) name(s) and age(s): _____

Step-sibling(s) name(s) and age(s): _____

Current living and custody arrangements, as applicable:

_____

NOTE: The word "family" in the following questions refers to ***parents, siblings, and all extended family members***. Please include a family member even if s/he is deceased by have been affected by any of the conditions below at ANY point in their life.

IS THERE A FAMILY HISTORY OF? ***(specify details and which family members)***

3a. **Substance Abuse**

Excessive or inappropriate use of alcohol?

Illegal substances, including but not limited to cocaine, marijuana, LSD, narcotics, amphetamines/ speed, Ecstacy?

Other substances, such as prescription medications or inhalants?

3b. **Mental Health Problems**, including but not limited to depression, anxiety, phobias, ADD/ ADHD, bipolar *(or manic-depressive)* disorder, schizophrenia, mental retardation, autism?

Psychiatric hospitalizations? _____

Suicide/suicide attempts? _____

Violence? _____

3c. Other significant physical or medical conditions for anyone in the family?

4. MEDICAL REVIEW

4a. Current pediatrician or family doctor? _____

Clinic/location: _____

4b. Please list any medical illnesses or conditions, past and present, that your child has experienced ***(e.g, high fevers, head injuries, seizures, surgeries)*:**

Is s/he being seen, or has been seen, by a medical specialist? (specify name, location, reason for treatment)

4c. What are your child's current medications? **Please list ALL medications and diagnoses** including over-the-counter medications and/or any herbal remedies being used:

Name	Dose	When/How Often	Prescribing MD	Results/Problems

5. MENTAL HEALTH REVIEW

Please list the mental health or behavioral health-related treatments and evaluations that your child has received in the past:

Type of Treatment (outpatient/hospital	Problems at the time	Therapist/facility	When/for how long

Past/recent statements or expressions of suicidal thoughts or wish to be dead ☐ Yes ☐ No
Past suicide attempts? ☐ Yes ☐ No
History of self harming, aggressive, or assaultive behavior? ☐ Yes ☐ No
Details of the above:

_____

_____

_____

Past medications for any mental health condition(s):

Type of Treatment *(outpatient/hospital)*	Problems at the time	Therapist/facility	When/for how long

6. OTHER COMMENTS:

_____

_____

_____

Completed by: _____ **Date:** _____
Signature