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631.828.2082 * 631.504.0476

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

Please use the backs of the pages for additional details.

GENERAL INFORMATION:

Today's Date: _____ Person Completing Form: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

Street

City

State

Zip

Home Phone: _____

Work Phone: Mother: _____ Father: _____

Cell Phone: Mother: _____ Father: _____

E-Mail: Mother: _____ Father: _____

School: _____ System: _____ Grade: _____

School's Telephone Number: _____

Teachers(s): _____

Who referred you to our office? _____

Please sign below if you give permission for us to thank this person:

Signature: X _____

Date: _____



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REASON FOR REFERRAL/CURRENT SYMPTOMS:

Please describe the problems your child is now having and the type of services you are seeking.

Please indicate if your child is experiencing any of the following difficulties:

- School attention/concentration problems
- Grades dropping or consistently low
- Hyperactive, difficulty being still
- Impulsive, doesn't think before acting
- Sadness or Depression
- Generalized Anxiety (across many situations)
- Specific fears/phobias (list): _____
- Social Anxiety
- Obsessive-Compulsive / Rigid behavior patterns
- Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- Isolated socially from peers
- Problems making or keeping friends
- Problems with eating
- Problems falling asleep
- Problems sleeping through the night (middle of the night or early morning waking)

- Trouble waking up
 - Fatigue/tiredness during the day
 - Nightmares
 - Noncompliant, purposely does not obey (not due to language or cognitive deficits)
 - Oppositional, defiant behavior
 - Problems controlling temper
 - Tantrums / “Meltdowns”
 - Problems with authority (breaking rules or laws)
 - Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
 - Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)
 - Self-injuries / Self-harm behavior (head banging, scratching, biting, cutting self)
 - Wetting accidents (indicate day or night wetting): _____
 - Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)
 - History of abuse (emotional, physical, sexual)
 - Alcohol or drug use/abuse
 - Vocal or motor tics (e.g. grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)
 - Sensory problems (over-reacts or under-reacts to light, sounds, tastes, textures, smells)
 - Stress from conflict between parents
 - Stress due to family financial problems
 - Legal situation (anyone in family)
- Other behavior problems: _____
- _____
- _____



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PARENTS / GUARDIANS AND FAMILY INFORMATION:

Mother's Name: _____ Age: _____

Occupation: _____ Education Completed: _____

Health: _____ Excellent _____ Good _____ Fair _____ Poor

Father's Name: _____ Age: _____

Occupation: _____ Education Completed: _____

Health: _____ Excellent _____ Good _____ Fair _____ Poor

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

If married, how long have you been married? _____

If divorced, how long have you been divorced? _____

If divorced, who has physical custody? _____ Is it full or joint? _____

Who has legal custody? _____ Is it full or joint? _____

****PLEASE PROVIDE A COPY OF THE CUSTODY AGREEMENT****

Has either parent been married before or since? Mother: _____ Father: _____

If yes, provide dates or other marriage(s), names, and ages of children from these marriages:

Mother: _____ Children and Ages: _____

Father: _____ Children and Ages: _____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Where does this parent live? _____

If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody, with stepsiblings, etc.?

How would you rate the quality of your present marriage?

Mother: _____ Great _____ Very Good _____ Good _____ Fair _____ Poor _____ Very Poor

Father: _____ Great _____ Very Good _____ Good _____ Fair _____ Poor _____ Very Poor



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Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain:

Who supervises the child's care when not in school? _____

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

<u>Sibling Name</u>	<u>Age</u>	<u>School</u>	<u>Grade</u> <u>Placement</u>	<u>Grade</u> <u>Average</u>	<u>Conduct*</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)

In general, how would you say the child for whom you are seeking services gets along with these siblings?

_____ Great _____ Very Good _____ Good _____ Fair _____ Poor _____ Very Poor

Describe: _____



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Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.).

Name	Age	Relationship to Child	Years Living in Home
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____
_____	_____	_____	From _____ To _____

Are there other relatives who have a significant impact on how this child is raised?

FAMILY STRESS LEVEL

Please rate overall stress level of FAMILY stress:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What is the greatest source of stress for this family at this time?

Please rate the overall stress in the mother's life:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What are the greatest sources of stress in the mother's life?

Please rate the overall stress in the father's life:

____ Very Low ____ Low ____ Average ____ High ____ Very High

What are the greatest sources of stress in the father's life?

How would you rate the overall level of happiness on a scale of 1 – 5 (1 = UNHAPPY, 5 = HAPPY)

Mother: _____ Father: _____



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FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorder? Check all that apply and list who.

<u>Yes</u>	<u>Condition</u>	<u>Family Member</u>
_____	General Developmental Delays or Cognitive Delay	_____
_____	Speech or Communication Disorder	_____
_____	Intellectual Disability (mental retardation)	_____
_____	Attention Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep Disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide Attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other Neurological Disorders	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X	_____
_____	Other: _____	_____

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:



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DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods or bed rest, etc.

Child was born: _____ premature _____ at full term _____ late

Birth Weight: _____ lbs. _____ oz

Difficulties following delivery? _____

Nursery (check all that apply): _____ Well-baby _____ Transitional _____ Intensive Care _____ Other

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.)

Any medical problems diagnosed in infancy? _____

As an infant, did this child seem:

_____ less active than average _____ average _____ overly active

As a toddler, did this child seem:

_____ less active than average _____ average _____ overly active

As a preschooler, did this child seem:

_____ less active than average _____ average _____ overly active

As the child entered school, did this child seem:

_____ less active than average _____ average _____ overly active

At what age did you child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet".

	Early	On-Time	Late	Approximate Age (if known)
<u>Speech and Language</u>				
Coo/babble	_____	_____	_____	_____
Respond to name	_____	_____	_____	_____
Say first word	_____	_____	_____	_____
Use gestures (wave, point)	_____	_____	_____	_____
Put words together	_____	_____	_____	_____
Speak in sentences	_____	_____	_____	_____
Follow simple directions	_____	_____	_____	_____
Follow multistep directions	_____	_____	_____	_____

	Early	On-Time	Late	Approximate Age (if known)
<u>Motor Skills</u>				
Roll over	_____	_____	_____	_____
Sit alone	_____	_____	_____	_____
Stand alone	_____	_____	_____	_____
Walk alone	_____	_____	_____	_____
Hold pencil correctly to mark	_____	_____	_____	_____
Write legibly	_____	_____	_____	_____
<u>Self-Help/Independence</u>				
Feed self	_____	_____	_____	_____
Toilet train (bladder)	_____	_____	_____	_____
Toilet train (bowel)	_____	_____	_____	_____
Dress-self	_____	_____	_____	_____
Bathe self	_____	_____	_____	_____
<u>Social/Emotional</u>				
Smile at others	_____	_____	_____	_____
Laugh aloud	_____	_____	_____	_____
Show affection	_____	_____	_____	_____
Engage in pretend play	_____	_____	_____	_____
First friendship	_____	_____	_____	_____
Control feelings when upset	_____	_____	_____	_____
Understand others' feelings	_____	_____	_____	_____
Show responsibility	_____	_____	_____	_____



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MEDICAL HISTORY

Name of Child's Primary Physician: _____

Physician's address: _____

Physician's Phone: _____

List any other physicians or health professionals your child sees for services on a regular basis:

When was your child last seen by a physician?

Rate your child's overall health: _____ Excellent _____ Good _____ Fair _____ Poor

Child's current height: _____ ft, _____ in. Weight: _____ lbs.

Does your child have any vision problems? _____

Date of last vision test and who performed (physician, optometrist, school) _____

Does your child have any hearing problems? _____

Date of last hearing test and who performed (physician, audiologist, school) _____

Is your child: _____ right handed _____ left handed _____ does not favor one hand



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List any operations, serious illnesses, injuries (especially head), hospitalization, allergies, ear infections, or other medical conditions your child has had.

List any medications your child is taking, including over-the-counter drugs, vitamins, and nutritional supplements (included dosages). Also list previous medications and dates if taken for an extended period of time. Use the back page if needed.

Describe your child's regular diet (i.e. favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to tastes, textures, overly restricted eating, overeating, unhealthy eating)?



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What is your child's typical bedtime and wake time each day? Any concern about your child's sleeping habits?

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?

EDUCATIONAL AND SOCIAL HISTORY

List in chronological order all schools your child has attended:

Name of School	Dates Attended	Grade Placement	Grade Average	Behaviorial Conduct*
1. _____	From _____ To _____	_____	_____	_____
2. _____	From _____ To _____	_____	_____	_____
3. _____	From _____ To _____	_____	_____	_____
4. _____	From _____ To _____	_____	_____	_____
5. _____	From _____ To _____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)



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Name of Current teacher(s): _____

What concerns does your child's teacher have about him/her?

What is your child's favorite subject? _____

What is your child's least favorite subject? _____

Has your child ever repeated a grade? _____ If so, which? _____

Has your child ever skipped a grade? _____ If so, which? _____

Has your child ever had tutoring? _____ Which subjects? _____

When and with whom? _____

Has your child ever been in a Special Education Program? _____ If so, what years? _____

How much of the school day? _____

What type of program? (LD, Gifted, ABD, ASD, etc.): _____

Child's attitude toward school: _____

How does your child interact with peers and adults in social situations? Do you have concerns about your child's social skills or development?

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

_____ Sports (list): _____

_____ Music (list): _____

_____ Clubs/Groups (list): _____

_____ Dance (list): _____

_____ Other: _____

Describe your child's strengths, positive qualities, and any special abilities or skills?

BEHAVIOR MANAGEMENT / DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use to each of the strategies listed: (circle the appropriate number)

	Very Unlikely					Very Likely
Let situation go	1	2	3	4	5	5
Time out	1	2	3	4	5	5
Send to room	1	2	3	4	5	5
Take away a privilege (ex. no TV)	1	2	3	4	5	5
Take away something material (ex. no dessert)	1	2	3	4	5	5
Assign an additional chore	1	2	3	4	5	5
Ground child	1	2	3	4	5	5
Yell at child	1	2	3	4	5	5
Physical punishment	1	2	3	4	5	5

List anything else you may do:

_____ 1 2 3 4 5

_____ 1 2 3 4 5



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Go back and rate the most THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Then, please circle the strategy that is LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Father: ____% Mother: ____% Other: ____% (Please specify): _____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

	Would like Child to do More Often	Would like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

LEGAL HISTORY

Have you ever filed or been involved in any litigation? Please explain.

Is there anything else we should know about your child that was not covered by this form?
