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Confidential Child/Adolescent Intake Questionnaire

To be filled out by parent, caretaker, caseworker or whoever is most informed about this young person's history. For me to be able to better understand this client, fill out the following intake form and questionnaires to the best of your ability. If there is insufficient space provided on this form, please continue on the back page. I realize there is a lot of information – and that you may not remember or have access to all of it. Please do the best you can. This form saves a lot of time during the initial sessions. If there is something that you do not want to put in writing, it is OK to communicate that information verbally. Do not hesitate to contact me if you have any questions. *Thank you!*

CLEINT IDENTIFICATION Name ______________________________

Date of Birth__________ Age _____ Sex _____ Ethnicity______________

Religion ____________With whom is the individual currently living? __________

This form filled out by ________________ Relationship ______________

Who will accompany this young person to appointments? ____________________

Name of adult Custodian(s) ______________________________

Address ______________________________

Home Phone ____________ Mobile ____________Work____________

Email ______________________________

Name of Mother (if different from above) ______________________________

Address ______________________________

Home Phone ____________ Mobile ____________Work____________

Email ______________________________

Name of Father (if different from above) ______________________________

Address ______________________________

Home Phone ____________ Mobile ____________Work____________

Email ______________________________

REFERRAL SOURCE ______________________________

Address ______________________________ Phone ____________

Do we have your permission to release information to the referring professional? Yes ____ No ____

GP/Paediatrician ______________________________

GP Address ______________________________ Phone ____________

Paediatrician Address ______________________________ Phone ____________

Do we have your permission to release information to your GP or Paediatrician? Yes ____ No ____

Main purpose of consultation Please give a brief summary of the main problems: ____________________

Why is this consultation being sought at this time? Please describe the main goals of being here: ________

Prior attempts to correct problem and previous mental health treatment Please include contact with other professionals, medications and types of treatment: ____________________

Medical history Current medical problems/medications: ____________________

Current supplements/vitamins/herbs: ____________________

Past medical problems/medications: ____________________

Prior hospitalizations (place, cause, date, outcome): ______________________________

Doctors/clinics seen regularly: ______________________________

Pregnancy complications (i.e. bleeding, excess medication, infections, smoking or alcohol/drug use during pregnancy): ______________________________

Any birth problems, trauma or complications: ______________________________

Any history of head trauma: ______________________________

Any history of seizures or seizure like activity: ______________________________

Prior abnormal lab tests, X-rays, EEG etc: ______________________________

Allergies/food or drug intolerances: ______________________________

Present Height __________ *Present Weight* __________

Any current physical health concerns: ______________________________

Current life stressors (include anything that is currently stressful for the individual being evaluated, examples include relationships, school, home circumstances, moving etc.): ______________________________

Sleep behaviour What time to bed, what time up? Quality of his/her sleep: ____________________________

Nightmares, recurrent dreams or sleepwalking: ____________________________

Bedwetting or soiling: ____________________________

Daytime incontinence: ____________________________

School history Current year: ____________ Last school attended: ____________________________

Typical grades received: ____________________________

Any problems at school or specific learning disabilities: ____________________________

Learning strengths: ____________________________

Any behavior problems in school: ____________________________

What have teachers said about the individual? ____________________________

Please bring school report cards and any previous testing that has been performed.

Employment history (if applicable): ____________________________

Any work-related problems: ____________________________

What would employers or supervisors say about the individual?: ____________________________

Legal problems or Family Court involvement: ______________________________

____

____

Sexual history (if applicable; answer only as much as you know about or feel comfortable telling)

Age at the time of first sexual experience: ________________ Number of sexual partners: ________________

Any history of sexually transmitted disease? _______________ History of abortion? _____________________

History of sexual abuse, molestation or rape: ______________________________

____

Current sexually related problems or issues: ______________________________

____

Alcohol and drug history Please list age started and types of substances used through the years and any current usage. These include alcohol (hard liquor, beer, wine), marijuana (real or synthetic), prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or 'P' or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms) etc: ______________________________

____

____

____

Past or present withdrawal symptoms from alcohol or drugs: ______________________________

____

Have your or anyone else told the individual they had a problem with drugs or alcohol?: _________________

____

Has the individual ever expressed guilt about drug or alcohol use?: ______________________________

____

Has the individual ever acted annoyed when someone talked to him or her about drug or alcohol use?: _____

____

Has the individual ever used drugs or alcohol first thing in the morning?: ______________________________

____

Caffeine use per day (caffeine is in coffee, tea, energy drinks and some sodas): ________________________

____

Past or present nicotine use (nicotine is in cigarettes, cigars and other tobacco products): _________________

____

Family structure (who lives in the individual's current household, please give relationship to each):

History of previous homes, families, placements etc:

Current satisfaction in home environment:

Significant developmental events (include divorces, deaths, traumatic events, losses, abuse, etc.):

Mother's history Biological, Adoptive or Step?: _______ Age_____ Employment (current and historical):

School - highest grade completed:

Any learning problems:

Any past or present behavior problems:

Marriages/partnerships:

Medical problems: ____

____

Childhood atmosphere (family position, abuse, illnesses etc): ______________________

____

____

Has mother ever sought mental health treatment? Yes ___ No ___ If yes, for what purpose? ________

____

____

Mother's alcohol/drug use history: ______________________________________

____

Please describe any learning problems or mental health problems in *biological* mother's blood relatives (including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations): ________

____

____

____

Father's history Biological, Adoptive or Step?: _______ Age_____ Employment (current and historical):

____

____

School - highest grade completed: ______________________________________

Any learning problems: ____

____

Any past or present behavior problems: __________________________________

____

Marriages/partnerships: ____

____

Medical problems: ____

____

Childhood atmosphere (family position, abuse, illnesses etc): ______________________

____

____

Has father ever sought mental health treatment? Yes ___ No ___ If yes, for what purpose? _________

____

____

Father's alcohol/drug use history: ____________________

Please describe any learning problems or mental health problems in biological father's blood relatives (including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations): ________

Siblings (names, ages, problems, strengths, quality of relationship to patient, living with or apart from client):

Cultural/Ethnic/Religious background (please describe cultural or religious practices that are important to the family): ____________________

Describe the individual's relationships with friends: ____________________

How does the person view himself or herself?: ____________________

Describe the individual's strengths: ____________________

Please report any other information you think it might be helpful for me to know about your child or this situation: ____________________

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