Patient Intake Questionnaire

General:
Child's Name _____
Date_____
Address _____
Age _____
Date of birth _____
Grade and school name _____

Parent/Guardian:
Home phone _____
Work phone _____
Fax _____
E-mail _____
Referred by _____

In the event of an emergency:
Make and Model of vehicle_____
Color_____license plate number_____

Siblings:
Names and ages of children
_____
Emergency contact information
_____

Areas of Concern:
What issues/concerns causes you to seek treatment? _____
_____
_____
_____
Do you have any specific goals with regard to your child's
treatment?_____
_____
_____
_____
Do you have any particular concerns/fears with regard to treatment?
_____
_____
_____
Psychological History
Has your child ever received psychotherapy/counseling? If yes, when_____
What was the focus of treatment?
_____
Did your child benefit from therapy?_____

Name of treating therapist(s), address (es), and telephone number(s)

_____

(An authorization for release of confidential information will be needed so that any former therapist may be contacted).

Has your child completed any psychological tests or assessments? If so, please provide name of test/assessment and date completed (if exact date is unknown, please approximate):

Name:_____Date:_____l_____l_____

Telephone Number:_____

(An authorization for release of confidential information will be needed so that any test administrator may be contacted)

Has your child been hospitalized due to psychiatric concerns? _____

if so, please provide dates and the nature of the concern_____

_____

Name of treating hospital, address, telephone number and treating psychiatrist

(An Authorization for release of confidential information Is needed prior to contact)

Are you currently taking any prescription medications?

_____

_____

Is your child prescribed medication. If so, please provide name and dosage_____

When did your child begin to take the medication?

_____

(An Authorization for release of confidential information will be needed so that health care provider may be contacted)

Has your child ever attempted suicide? _____When? _____

Describe the circumstances that led to that attempt

_____

_____

Any current suicidal thoughts? Please describe

_____

Please describe your child's childhood

_____

_____

_____

_____

Has your child been subjected to verbal, physical, emotional, sexual abuse? Please describe

_____

_____

_____

Has your child ever been a victim of a violent crime? Please describe
_____

Medical History:
Has your child ever been diagnosed with a serious
illness?_____
_____
_____

Does your child have any medical conditions that may affect treatment?
_____
_____
Please describe your child's overall health today
_____
_____
_____

Please describe your pregnancy. Did you deliver at term? Problems/complications?
_____
_____
_____
During pregnancy did you suffer with depression or anxiety?
_____
_____
_____
During your pregnancy did you use alcohol, substances, or smoke cigarettes, use caffeine?
_____
_____
_____
Did your child attain developmental milestones?_____

Family of Origin History:
Mother's name, age, description of relationship:
_____
Father's name, age, description of relationship:
_____

Names and ages of siblings:
_____
_____

Do you have a faith or religion?
_____

Please feel free to include any other information that you believe important

_____
_____
_____

Thank you for taking the time to complete this.