**PARENT INTAKE QUESTIONAIRRE**

**FAMILY DEMOGRAPHICS**

Client Name: Today’s Date:

Date of Birth: Age:

Current School: Grade:

Guardian #1: Guardian #2:

Relationship: Relationship:

Address: Address:

City, State, Zip: City, State, Zip:

Telephones: Telephones:

Email: Email:

Highest Level of Education: Highest Level of Education:

Occupation: Occupation:

Employer: Employer:

May I leave messages at any phone number listed above? Yes No

Are there others living in the home or siblings outside the home? Yes No

If so, please list them below:

|  |  |
| --- | --- |
| Name:  Age:  Relationship: | Name:  Age:  Relationship: |
| Name:  Age:  Relationship: | Name:  Age:  Relationship: |

Emergency contact:

Phone: Relationship:

Referred by:

**STRENGTHS AND CONCERNS**

What are your child’s strengths? What is going well with your child?

How is your child’s academic ability and performance?

Please describe the concerns that brought you here today:

When did the concerns begin?

How is family functioning?

How is the relationship between parents/caregivers in the home?

**PRENATAL AND EARLY DEVELOPMENT**

Were there any complications during the pregnancy or delivery of your child?

Did either parent use substances during your child’s pregnancy or early childhood?

Did a doctor ever express concerns about your child during their infancy or early childhood?

At what age did your child crawl?

At what age did your child walk?

At what age did your child say their first word?

At what age did your child toilet train?

Has your child ever experienced night terrors? If so, what ages?

**PLEASE CHECK ANY OF THE BELOW SYMPTOMS YOUR CHILD IS EXPERIENCING:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Depression |  | Feeling of extreme happiness |
|  | Extreme sadness |  | School Problems |
|  | Trouble concentrating |  | Problems getting along with friends or family |
|  | Memory problems |  | Cold / Flu |
|  | Feeling hopeless |  | Injuries |
|  | Lack of energy |  | Chronic Health Conditions |
|  | Feeling tearful |  | Physical complaints of pain |
|  | Lack of enjoyment of usual activities |  | Bed Wetting |
|  | Change in eating habits |  | Disordered Eating |
|  | Change in sleeping habits |  | Weight changes |
|  | Loss or Grief |  | Substance Abuse |
|  | Perfectionism |  | Feeling stressed |
|  | Feeling fearful |  | Easily irritated |
|  | Feeling guilty |  | Problems with anger |
|  | Feeling nervous |  | Acting violently |
|  | Obsessions or compulsions |  | Legal Problems |
|  | Sudden feelings of panic |  | Thoughts of hurting self or others |
|  | Low Self Esteem |  | Thoughts of killing self or others |

**MEDICAL INFORMATION**

Has your child seen a doctor in the last year? Yes No

Why did they see a doctor?

Who is your child’s doctor?

Doctor’s phone:

Does your child have any allergies?

Does your child have any current or past diagnoses?

Please list any medications your child is taking below:

|  |  |
| --- | --- |
| MEDICATION | DOSAGE |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

**SUBSTANCE ABUSE HISTORY**

Please describe any current or past use of:

Tobacco (any form)?

Alcohol?

Caffeine (any form)?

Mind-altering substances (drugs)?

**COUNSELING HISTORY**

Has your child ever been to counseling before? Yes No

If so, please describe each counseling experience below (most recent first):

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes: