INTAKE DATE _____ THERAPIST _____ DIAGNOSIS: _____GAF _____

CLIENT INFORMATION QUESTIONNAIRE: CHILD WHO REFERRED YOU TO US? _____
(Child up to age 13; for ages 14-18, parent fill out child intake, child fill out adult intake)

CHILD'S NAME: _____ AGE: _____ SEX: M ___ F ___ BIRTHDATE: _____

CHILD RESIDES WITH: (check all that apply) MOTHER ___ FATHER ___ STEPMOTHER_____ STEPFATHER _____ OTHER_____

MOTHER'S NAME: _____ SS# _____BIRTHDATE: _____

HOME ADDRESS: _____ HOME PHONE: _____

_____ WORK PHONE: _____

CELL PHONE: _____

MOTHER'S EMPLOYER: _____

WORK ADDRESS: _____
Street City State Zip Code

WORK HOURS: _____ OCCUPATION: _____

FATHER'S NAME: _____ SS# _____ BIRTHDATE: _____

HOME ADDRESS: _____ HOME PHONE: _____

_____ WORK PHONE: _____

CELL PHONE: _____

FATHER'S EMPLOYER: _____

WORK ADDRESS: _____
Street City State Zip Code

STEPMOTHER'S NAME: _____HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

STEPFATHER'S NAME: _____HOME PHONE: _____WORK PHONE: _____ CELL PHONE _____

RELIGIOUS AFFILIATION: _____ HOW IMPORTANT? VERY ___ SOME ___ LITTLE __ NONE_____

PRIMARY HEALTH INS: _____SUBSCRIBER ID: _____ GROUP #_____

CLAIMS ADDRESS: _____ PHONE # _____

PREAUTHORIZATION REQUIRED FOR MENTAL HEALTH SERVICES ? YES ___ NO ___

DEDUCTIBLE IS: $ _____ DEDUCTIBLE MET FOR THIS YEAR: YES ___ NO _____ LEFT $ _____

OUTPATIENT MENTAL HEALTH BENEFITS (IF KNOWN): _____

SECONDARY HEALTH INS: _____SUBSCRIBER ID: _____Group # _____

CLAIMS ADDRESS: _____ PHONE # _____

HAS YOUR CHILD RECEIVED PSYCHOLOGICAL SERVICES THIS YEAR? yes __ no __ EVER? yes __ no __WHEN? FOR HOW LONG? WITH WHOM?

_____

_____
Child's Name

IN CASE OF EMERGENCY: (CLOSE RELATIVE NOT LIVING AT HOME)

NAME _____ HOME PHONE _____ WORK _____ CELL _____

ADDRESS _____ CITY- _____ STATE _____ ZIPCODE _____

CHILD'S PHYSICIAN: _____ _____
Name Phone

DATE IF CHILD'S LAST VISIT WITH A PHYSICIAN? _____ WHY? _____

DOES YOUR CHILD HAVE ANY ALLERGIES? IF SO TO WHAT? _____

LIST ANY HEALTH PROBLEMS FOR WHICH YOUR CHILD HAS RECEIVED TREATMENT: _____

_____

LIST ANY MEDICATIONS (PRESCRIPTION, OVER THE COUNTER AND SUPPLEMENTS) YOUR CHILD TAKES :

_____

LIST ANY HOSPITALIZATIONS OR EMERGENCY ROOM CONTACTS YOUR CHILD HAS HAD: _____

_____

WHY ARE YOU SEEKING PSYCHOLOGICAL SERVICES FOR YOUR CHILD? _____

_____

HOW SEVERE ARE YOUR CHILD 'S CURRENT DIFFICULTIES ? Mild ____ Moderate ____ Severe ____ Very Severe ____ Extremely Severe ____

IF THERAPY IS EFFECTIVE IN REDUCING OR RESOLVING YOUR CHILD'S PROBLEMS, HOW WILL HIS/HER LIFE BE DIFFERENT?

_____

_____

CHILD'S CURRENT FAMILY: Include biological and step-siblings, deceased members, and anyone else who regularly resides with or plays a significant role in the child's life)

Name	Age	Relationship	City of Residence	School Grade or Occupation

HAVE ANY MEMBERS OF THE CHILD'S IMMEDIATE OR EXTENDED FAMILY HAD A HISTORY OF ANY OF THE FOLLOWING :
(M=mother F=father, S=sister, B=brother, A= aunt, U=uncle, O=other)

depression ____ anxiety ____ phobias/fears ____ alcohol abuse ____ drug abuse ____aggressiveness ____ convicted of a crime _____

learning disability ____ hyperactivity ____ seizures _____ psychiatric hospitalization ____ schizophrenia ____

attempted suicide ____ completed suicide ____ emotional abuse ____ physical abuse ____ sexual abuse ____ DWI/DUI ___

ADDITIONAL INFORMATION: _____

_____
Child's Name

HOW CONCERNED ARE YOU ABOUT THESE AREAS OF YOUR CHILD'S LIFE? (0-10 ; 10= very concerned)
family ____ friends ____ school _____ leisure time _____ legal situation ____ health _____

CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

bedwetting	poor self-esteem	shy	nervous	fears	angry	eats too little	eats too much
temper tantrums	nightmares	sad	hurts others	hurts self	poor grades	misbehaves	messy
restlessness	agitated	lonely	worrying	lazy	anxious	restless	
lying	bored	moody	headaches	impulsive	smoking	alcohol/drug use	sleep problems
worrying	dishonest	unmotivated	irritable	sexually abused	depressed	school absences	forgetful
suicidal thoughts	lacks self control	doesn't finish tasks		easily frustrated	feels unloved	feels ashamed	argues
trouble concentrating		trouble making decisions		physically abused		pessimistic	poor self control
unable to have a good time		stomach troubles		other: _____			

ARE YOU CONCERNED ABOUT YOUR CHILD'S DRINKING OR OTHER DRUG USE? yes ___ no ___

ARE THERE PEOPLE IN YOUR CHILD'S HOME WHO DRINK ALCOHOL MORE THAN TWICE A WEEK OR IN EXCESS, OR USE OTHER DRUGS? yes__ no__

HAVE YOU EVER THOUGHT THAT ANYONE IN YOUR CHILD'S HOME SHOULD CUT DOWN ON THEIR DRINKING OR DRUG USE? yes ___ no ___

COULD SOMEONE ELSE'S DRINKING OR DRUG USE BE THE CAUSE OF ARGUMENTS OR OTHER FAMILY PROBLEMS? yes ___ no ___

FINISH THE FOLLOWING SENTENCES REGARDING YOUR CHILD:

1) MY CHILD IS A PERSON WHO _____

2) WHAT MY CHILD NEEDS NOW IS _____

3) WHAT MAKES MY CHILD REALLY SPECIAL IS _____

TO BE COMPLETED BY THERAPIST: ADDITIONAL NOTES AND ASSESSMENT

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Therapist Signature

_____
Date