



Intake Questionnaire (Children & Adolescents)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____ **Social Security Number:** _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Home Address: _____ **City/State/Zip code:** _____

Home Phone: _____ **Cellular/Alternate Phone:** _____

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

How long has this been going on?

What made you come in at this time?

What do you hope to gain from this evaluation and/or counseling?

If you had difficulties in the past, what have you done to cope? Was it helpful?

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- | | |
|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Difficulty getting out of bed | <input type="checkbox"/> Not feeling rested in the morning |
| Average hours of sleep per night: _____ | |
| <hr/> | |
| <input type="checkbox"/> Persistent loss of interest in previously enjoyed activities | |
| <input type="checkbox"/> Withdrawing from other people | <input type="checkbox"/> Spending increased time alone |
| <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Feeling Numb |
| <input type="checkbox"/> Rapid mood changes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Frequent feelings of guilt | <input type="checkbox"/> Avoiding people, places, activities or specific things |
| <input type="checkbox"/> Difficulty leaving your home | |
| <input type="checkbox"/> Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____ | |
| <input type="checkbox"/> Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands) | |
| <input type="checkbox"/> Outbursts of anger | |
| <hr/> | |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Helplessness |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Feeling or acting like a different person |
| <hr/> | |
| <input type="checkbox"/> Changes in eating/appetite | |
| <input type="checkbox"/> Eating more | <input type="checkbox"/> Eating less |
| <input type="checkbox"/> Voluntary vomiting | <input type="checkbox"/> Use of laxatives |
| <input type="checkbox"/> Excessive exercise to avoid weight gain | <input type="checkbox"/> Binge eating |
| <input type="checkbox"/> Are you trying to lose weight? _____ | |
| <input type="checkbox"/> Weight gain: _____ lbs | <input type="checkbox"/> Weight loss: _____ lbs. |
| <hr/> | |
| <input type="checkbox"/> Difficulty catching your breath | <input type="checkbox"/> Increase muscle tension |
| <input type="checkbox"/> Unusual sweating | <input type="checkbox"/> Easily started, feeling “jumpy” |
| <input type="checkbox"/> Increased energy | <input type="checkbox"/> Decreased energy |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Frequent worry | <input type="checkbox"/> Physical sensations others don’t have |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Intrusive memories |
| <hr/> | |
| <input type="checkbox"/> Difficulty concentrating or thinking | <input type="checkbox"/> Large gaps in memory |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Thoughts about harming or killing yourself | <input type="checkbox"/> Thoughts about harming or killing someone else |
| <hr/> | |
| <input type="checkbox"/> Feeling as if you were outside yourself, detached, observing what you are doing | |
| <input type="checkbox"/> Feeling puzzled as to what is real and unreal | |
| <input type="checkbox"/> Persistent, repetitive, intrusive thoughts, impulses, or images | |
| <input type="checkbox"/> Unusual visual experiences such as flashes of light, shadows | |
| <input type="checkbox"/> Hear voices when no one else is present | |
| <input type="checkbox"/> Feeling that your thoughts are controlled or placed in your mind | |
| <input type="checkbox"/> Feeling that the television or the radio is communicating with you | |

- | | |
|--|---|
| <input type="checkbox"/> Difficulty problem solving | <input type="checkbox"/> Difficulty meeting role expectations |
| <input type="checkbox"/> Dependency on others | <input type="checkbox"/> Manipulation of others to fulfill your own desires |
| <input type="checkbox"/> Inappropriate expression of anger | <input type="checkbox"/> Self-mutilation/cutting |
| <input type="checkbox"/> Difficulty or inability to say "no" to others | <input type="checkbox"/> Ineffective communication |
| <input type="checkbox"/> Sense of lack of control | <input type="checkbox"/> Decreased ability to handle stress |
| <input type="checkbox"/> Abusive relationship | <input type="checkbox"/> Difficulty expression emotions |
| <input type="checkbox"/> Concerns about your sexuality | |

Sexual Orientation: Heterosexual Homosexual Bisexual I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

No Yes If so:

Name of therapist: _____ Dates of Treatment _____
Reason for seeking help: _____

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Reason for seeking help: _____

Name of therapist: _____ Dates of Treatment _____
Reason for seeking help: _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? No Yes If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you been on **PSYCHIATRIC** medication in the past? No Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of Medication

Have you been hospitalized for psychiatric reasons? No Yes If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? No Yes If YES, describe:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? No Yes If YES, describe:

List any **PRIOR** illnesses, operations and accidents

FAMILY HISTORY

Father: Age: Living Deceased Cause of death:
 If deceased, HIS age at time of his death____ YOUR age at time of his death____
 Occupation: _____ Health: _____
 Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: Living Deceased Cause of death:
 If deceased, HER age at time of his death____ YOUR age at time of his death____
 Occupation: _____ Health: _____
 Frequency of contact with him: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				No	Yes
				No	Yes
				No	Yes
				No	Yes
				No	Yes

During your childhood, have you lived any significant period of time with anyone other than your natural parents?

No Yes If so, please give the persona's name and relationship to you

Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems						
Depression						
Hyperactivity						
Counseling						
Psychiatric Medication						
Psychiatric Hospitalization						
Suicide Attempt						
Death by Suicide						
Drinking Problem						

SOCIAL HISTORY

Education

Highest grade level completed so far: _____

Have you had any disciplinary problems in school? _____

If yes, please explain: _____

What kinds of grades do you get in school? _____

Legal

Have you been arrested or had any contact with the police? _____

If yes, please describe: _____

Religion

Do you have a religious affiliation?

If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?

___ Verbally ___ Emotionally ___ Physically ___ Sexually ___ Neglected

Please describe:

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use _____

How much do you drink? _____

How often do you drink? _____

Do you use tobacco (cigarettes, dip)? _____

If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?