Intake Questionnaire For New Patients (Child/Minor)

This questionnaire is for the purpose of getting to know the minor better in order to provide the best possible mental health services. Please complete this form with the minor 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 rewards and disciplines have you tried? Was it helpful?

_____
_____
_____

Symptoms

Please **check** any symptoms or experiences that the minor has had **in the last month**

☐	Difficulty falling asleep	☐	☐	Difficulty staying asleep
☐	Difficulty getting out of bed	☐	☐	Not feeling rested in the morning
☐	Average hours of sleep per night: _____			
☐	Persistent loss of interest in previously enjoyed activities			
☐	Withdrawing from other people	☐	☐	Spending increased time alone

	Depressed Mood			Feeling Numb
	Rapid mood changes			Irritability
	Anxiety			Panic attacks
	Frequent feelings of guilt			Avoiding people, places, activities or specific things
	Difficulty leaving your home			
	Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____			
	Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)			
	Outbursts of anger			
	Worthlessness			Hopelessness
	Sadness			Helplessness
	Fear			Feeling or acting like a different person
	Changes in eating/appetite			
	Eating more			Eating less
	Voluntary vomiting			Use of laxatives
	Excessive exercise to avoid weight gain			Binge eating
	Are you trying to lose weight? _____			
	Weight gain: _____ lbs			Weight loss: _____ lbs.
	Difficulty catching your breath			Increase muscle tension
	Unusual sweating			Easily started, feeling "jumpy"
	Increased energy			Decreased energy
	Tremor			Dizziness
	Frequent worry			Physical sensations others don't have
	Racing thoughts			Intrusive memories
	Difficulty concentrating or thinking			Large gaps in memory
	Flashbacks			Nightmares
	Thoughts about harming or killing yourself			Thoughts about harming or killing someone else
	Feeling as if you were outside yourself, detached, observing what you are doing			
	Feeling puzzled as to what is real and unreal			
	Persistent, repetitive, intrusive thoughts, impulses, or images			
	Unusual visual experiences such as flashes of light, shadows			
	Hear voices when no one else is present			
	Feeling that your thoughts are controlled or placed in your mind			
	Feeling that the television or the radio is communicating with you			
	Difficulty problem solving			Difficulty meeting role expectations
	Dependency on others			Manipulation of others to fulfill your own desires
	Inappropriate expression of anger			Self-mutilation/cutting
	Difficulty or inability to say "no" to others			Ineffective communication
	Sense of lack of control			Decreased ability to handle stress
	Abusive relationship			Difficulty expression emotions
	Concerns about your sexuality			

Sexual Orientation:		Heterosexual		Homosexual		Bisexual		I choose not to answer

Please describe any other symptoms or experiences the minor has had problems with:

_____

_____

_____

_____

Has the minor 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: _____ _____

Name of therapist: _____ Dates of Treatment

Reason for seeking help: _____ _____

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

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

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

Medication	**Dosage**	**How long have you been taking it?**

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

Hospital	**Dates**	**Reason**

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

_____

_____

_____

_____

MEDICAL HISTORY

Are they **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____ MINORS age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are they/Have they been close to him? _____

Mother: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HER age at time of his death___ MINORS age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with her: _____ Are they/Have they 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**

Has the minor lived any significant period of time with anyone other than their 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 theycompleted ? _____
Do they had any disciplinary problems in school? _____
If yes, please explain: _____
Were they considered hyperactive/ADHD in school?_____
Do they expeience bulling? If yes, when?_____
Do they participate in after-school program? _____
Do they enjoy goin to school? _____
What kinds of grades do they get in school?_____

Have they been arrested or had any contact with the police?_____
If yes, please describe: _____

Do they have a religious affiliation?_____
If yes, what is it? _____

What kind of social activities do they participate in?_____

Who do they turn to for help with their problems?_____

Have you ever been abused?

	Verbally		Emotionally		Physically		Sexually		Neglected

Please describe: _____
_____

SUBSTANCE ABUSE

Alcohol
Do they drink alcohol?_____ If yes, age of first use _____
How much do they drink?_____
How often do they drink?_____
Do they 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 the minor?

_____
_____