

CHILD AND ADOLESCENT INTAKE QUESTIONNAIRE-PARENT FORM

Child's Name: _____ Date: _____
 First Middle Last

Birthdate: _____ Current Age: _____
 Month Day Year Years / Months

Address: _____

Phone Numbers: _____
 Home Mother's Cell Father's Cell

Current School: _____

Address

Phone Number Fax Number

Main Teacher Principal

Grade: _____ Type of Class (Regular, EH, ED, Resource, GATE, Etc.) _____

Placement Status (SST, 504, IEP, AB 3632, Etc.) _____



FAMILY INFORMATION

Parent 1: _____
 Name Age Highest Degree Attained in School
Biological () Adoptive () Step () Foster ()

Current Occupation

Address and Phone Number, if different from child's

Parent 2: _____
 Name Age Highest Degree Attained in School
Biological () Adoptive () Step () Foster ()

Current Occupation

Address and Phone Number, if different from child's

OTHER CHILDREN IN THE HOME	AGE	GRADE

OTHERS LIVING IN THE HOME	AGE	RELATIONSHIP TO YOUR CHILD

PARENTS' MARITAL STATUS

Current: Date of...Marriage _____ Separation _____ Divorce _____
 Prior: Mother married to _____ Date Separated _____ Date divorced _____
 Father married to _____ Date Separated _____ Date divorced _____

OTHER TREATING CLINICIANS

REFERRED BY _____
 Name _____ Phone Number _____
 Address _____

THERAPIST _____
 Name _____ Phone Number _____
 Address _____

PRIMARY CARE _____
 Name _____ Phone Number _____
 Address _____

OTHER _____
 Name _____ Phone Number _____
 Address _____

LIST ALL CURRENT MEDICATIONS, VITAMINS, ADDITIVES AND HERBAL SUPPLEMENTS

NAME	DOSE	REASON OR PURPOSE	RESULT/EFFECT

REASON FOR BEING HERE AT THIS TIME

CURRENT PROBLEMS: What brings you here? Please briefly describe your child's current problems starting with the most serious.

ONSET: How long ago did the problems begin? How old was your child? Was there a precipitant? Were there any major stresses happening in the family at the time the problems began?

TREATMENT: What kinds of interventions have been tried? Have you tried medications, seen other therapists, used any "non-traditional" treatments?

FAMILY RELATIONSHIPS: Describe what effects the problems have had on family relationships and family functioning. How does your child get along with each parent and with each brother and/or sister.

SCHOOL: Describe your child's function at school. Are there any problems? What are his/her school-related likes and dislikes?

PEER RELATIONSHIPS: Describe how your child gets along with other children. Who are his/her best friends? Have his/her problems affected these relationships?

PAST PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OTHER PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS AT ANY OTHER TIME? Please describe other mental health problems and what interventions have been made. What have been the results of these interventions?

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S MENTAL HEALTH?

CHILD'S MEDICAL HISTORY

PAST AND PRESENT MEDICAL HISTORY:

Has your child ever been hospitalized? When and why?

Has your child *ever* had any serious medical illnesses? Please describe all illnesses and their treatments.

Does your child *currently* have any serious medical illnesses? Please describe all current illnesses and their treatments.

Has your child ever had any serious injuries? Please include *all* head injuries. Describe all injuries and their treatments. Did any require hospitalization?

Has your child ever had surgery? Please describe the surgery. Include the date and outcome.

Does your child have any allergies? Please include all medication allergies or food allergies. Has your child ever had any life threatening allergic reactions?

Does your child have asthma? Has it ever required visits to the emergency room or hospitalization? Please describe the seriousness of the asthma and its past and current treatments.

Does your child currently take, or has he/she ever taken, any medication for psychiatric or behavior problems? List all medications used for these problems. Include both past and present medication use.

NAME	DOSE	REASON OR PURPOSE	RESULT/EFFECT

Has your child ever tried, or does your child currently use, any chemical substances? Please list alcohol, tobacco, illegal substances, over-the-counter medications and prescription medications.

Has your child ever been in trouble at home, at school or with the law because of substance use? Please explain.

HEARING	YES	NO	NOT SURE
Did your child have recurrent or chronic ear infections? _____			
Did he/she require surgery and/or tube placement? _____			
Has your child ever had a hearing problem? _____			
Has anyone ever questioned your child's ability to hear? _____			

VISION	YES	NO	NOT SURE
Has your child ever had eye or vision problems? _____			
Has your child been treated for strabismus or "lazy eye"? _____			
Has your child ever had any type of eye or vision therapy? _____			
Does your child wear prescription glasses or contacts? _____			

NEUROLOGICAL PROBLEMS	YES	NO	NOT SURE
Has your child had:			
Head trauma or been hit in the head _____			
Severe headaches _____			
Seizures _____			
Seizures only with high fevers _____			
Encephalitis _____			
Meningitis _____			
Loss of consciousness or black outs _____			
Fainting _____			
Momentary lapses of consciousness _____			
Trance-like episodes _____			
Chronic dizziness _____			
Double vision _____			
Tremor _____			
Unexplained poor coordination _____			
Trouble walking _____			
Memory problems _____			

TOXIC OR DANGEROUS CHEMICALS OR MATERIALS	YES	NO	NOT SURE
Has your child been exposed to:			
Insulation _____			
Asbestos _____			
Fumes _____			
Metals _____			
Lead _____			
Mercury _____			
Chemicals _____			
Plastics _____			
Solvents _____			
Dyes _____			

Has your child traveled to a foreign country in the last 10 years? YES NO NOT SURE

Where? _____ When? _____

Are immunizations up to date? YES NO NOT SURE

How is your child's general health currently? _____

Does your child now, or has your child had a past history of, any problems with his or her:

	NOW	IN THE PAST	NEVER	PLEASE EXPLAIN
Head				
Eyes				
Ears				
Nose				
Throat				
Respiratory system				
Shortness of breath				
Chest (i.e. pain)				
Heart or blood vessels				
Digestive tract				
Liver (hepatitis, etc)				
Genito-Urinary tract				
Bones				
Muscles				
Hormone system				
Brain or nerves				
Sleep				
Appetite				

Girls: Age at first menstrual period _____
 Is menstruation regular? _____
 Are there any difficulties related to menstrual periods? Please explain _____

Is your child sexually active? YES NO NOT SURE
 Does he/she have a regular girl- or boy-friend? YES NO NOT SURE

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S MEDICAL HISTORY?

FAMILY HISTORY

Blood relatives including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc. Include everyone known to you.

FAMILY MEDICAL HISTORY:

GENERAL HEALTH

	NAME	GOOD	POOR	DIED	AGE	ILLNESS OR CAUSE OF DEATH
Father	_____					
Mother	_____					
Brothers	1. _____					
	2. _____					
	3. _____					
	4. _____					
Sisters	1. _____					
	2. _____					
	3. _____					
	4. _____					

Have any of your child's relatives ever had any of the following:

	YES	NO	RELATIONSHIP TO YOUR CHILD
Migraine or other chronic headaches _____			
Seizures/Epilepsy _____			
Stroke _____			
High or Low Blood Pressure _____			
Heart Disease _____			
Heart Attack _____			
Heart Murmur _____			
Tuberculosis _____			
Emphysema _____			
Lung Disease _____			
Asthma _____			
Hay Fever _____			
Stomach Ulcers _____			
Gastric Reflux Disease _____			
Gallstones _____			
Diabetes _____			
High Cholesterol _____			
Liver Disease _____			
Hepatitis _____			
Kidney or Renal Disease _____			
Nephritis _____			
Thyroid Disease _____			
Arthritis _____			
Obesity _____			
Infectious Disease _____			
HIV/AIDS _____			
Glaucoma _____			
Gout _____			
Anemia _____			
Allergies _____			
Hemophilia or Bleeding Tendencies _____			
Sudden Unexplained Death _____			
Alzheimer's Disease _____			
Dementia _____			
Cancer _____			
Genetic Disorder _____			

DOES ANY FAMILY MEMBER HAVE ANY OTHER MEDICAL ILLNESS OR DISORDER, INCLUDING HEREDITARY DISORDERS, I SHOULD KNOW ABOUT?

FAMILY PSYCHIATRIC ILLNESS: Blood relatives, including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc. Include everyone known to you.

Have any of your child's relatives ever had any of the following:

	YES	NO	RELATIONSHIP TO YOUR CHILD
Depression _____			
Manic Depressive (Bipolar) Disorder _____			
Post Partum Depression _____			
Post Partum Psychosis _____			
Suicide _____			
Anxiety Disorder _____			
Panic Disorder _____			
Separation Anxiety _____			
Agoraphobia _____			
Other Phobias _____			
Obsessive Compulsive Disorder _____			
Post-Traumatic Stress Disorder _____			
Other Stress Disorder _____			
Anorexia _____			
Bulimia _____			
Schizophrenia _____			
Other Psychotic Disorder _____			
ADHD _____			
ADD _____			
Oppositional Defiant Disorder _____			
Conduct Disorder _____			
Antisocial Personality Disorder _____			
Tourette's Disorder _____			
Other Tic Disorder _____			
Autism _____			
Asperger's Disorder _____			
Other Pervasive Developmental Disorder _____			
Alcoholism _____			
Substance Abuse _____			
Psychiatric Hospitalizations _____			

Explain any "Yes" answers. Please include the disorder, relationship of the individual to your child, any treatment that person has received, and the results of any treatment.

Has any family member ever taken any psychiatric or mental health medication?

WHO WAS IT?	MEDICATION	PURPOSE	EFFECT OR RESULT

Has any family member ever had ECT (electroconvulsive therapy) or "shock treatment"?

WHO WAS IT?	PURPOSE	EFFECT OR RESULT

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S FAMILY'S PSYCHIATRIC OR MENTAL HEALTH HISTORY?

OTHER FAMILY HISTORY: Blood relatives, including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc. Include everyone known to you.

Has any relative of your child ever had or experienced any of the following:

	YES	NO	RELATIONSHIP TO YOUR CHILD	PLEASE DESCRIBE THE PROBLEM
School Problems				
Learning Disabilities				
Dyslexia				

LEGAL HISTORY: Has any family member ever been arrested or incarcerated? Please explain.

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S FAMILY'S HISTORY OR EXPERIENCES?

CHILD'S DEVELOPMENTAL HISTORY

PREGNANCY

1. Did your child's biological mother have any difficulties or complications during her pregnancy with this child?

	YES	NO	NOT SURE
Spotting or light bleeding _____			
Heavy bleeding requiring bed rest or special treatment _____			
Excessive nausea or vomiting lasting more than 3 months _____			
Weight gain over 30 pounds _____			
Weight gain under 20 pounds _____			
High blood pressure and/or excessive fluid build up _____			
Convulsions during pregnancy _____			
Toxemia _____			
Pre-eclampsia _____			
Gestational diabetes _____			
Threatened miscarriage or early contractions _____			
Accidents requiring medical care _____			
Infection (like a kidney infection) requiring medical care _____			
Illnesses requiring medical care _____			
Anemia _____			
Diabetes _____			
Heart disease _____			
Kidney disease _____			
Measles/German measles _____			
Flu or other virus _____			
Exposure to X-rays just prior to or during pregnancy _____			
Was this pregnancy considered "high risk"? _____			
Maternal age over 40 years _____			
Maternal age under 20 years _____			
Was the pregnancy shorter than 38 weeks? _____			
Was the pregnancy longer than 42 weeks? _____			

2. Were any medications prescribed during this pregnancy? _____
 Were any medications taken during this pregnancy? _____
 If "yes" which medications and during which trimester? _____

3. During pregnancy, did your child's biological mother engage in any of the following?

Smoking tobacco _____ YES NO NOT SURE
 If "yes", how much and during which trimester? _____

Drinking alcohol _____ YES NO NOT SURE
 If "yes", what kind of alcohol, how much and during which trimester? _____

Any drug use (i.e. marijuana, cocaine, ecstasy, etc.)
If "yes", which drugs and during which trimester?

YES NO NOT SURE

PREGNANCY-RELATED

1. Was this pregnancy planned? YES NO NOT SURE
2. Was there a preference for a boy or a girl?
Boy _____ YES NO NOT SURE
Girl _____
3. Was this your child's biological mother's first pregnancy? YES NO NOT SURE
How many prior live births? _____
How many prior miscarriages? _____
How many prior terminated pregnancies? _____

BIRTH

1. Were there any complications at the time of delivery?
- | | YES | NO | NOT SURE |
|---|-----|----|----------|
| Did the water break more than 24 hours before delivery? _____ | | | |
| Prolonged labor (longer than 4 hours) _____ | | | |
| Was labor induced? _____ | | | |
| Was this child born breech (feet or head first) _____ | | | |
| Were forceps used? _____ | | | |
| Was suction used? _____ | | | |
| Was this a planned Caesarian section delivery? _____ | | | |
| Was there an emergency Caesarian section? _____ | | | |
| Was anesthesia used? _____ | | | |
| Were there seizures? _____ | | | |
2. What was this child's birth weight? _____
3. What were the Apgar scores at 1 minute? _____
at 5 minutes? _____

NEONATAL PERIOD AND INFANCY

1. Neonatal period
- | | YES | NO | NOT SURE |
|---|-----|----|----------|
| Was oxygen required? _____ | | | |
| Did the baby require an incubator? _____ | | | |
| Was this baby in the neonatal ICU? _____ | | | |
| Did the baby remain in the hospital after the birth mother went home? _____ | | | |
| Did the baby have jaundice? _____ | | | |
| Were there any difficulties with breathing? _____ | | | |
| Were there blood transfusions? _____ | | | |
| Were there seizures? _____ | | | |
2. Infancy: Was there anything unusual, different or difficult about this child during the first 12 months of life?
- | | | | |
|---|--|--|--|
| Was surgery required? (Don't include circumcision or tongue clipping) _____ | | | |
| Had to switch formulas 3 times or more _____ | | | |
| Had to use non-milk products _____ | | | |
| Cried day and night, couldn't be consoled _____ | | | |
| Too quiet or "too good" _____ | | | |
| Stiffened up when held, or pushed you away _____ | | | |
| Floppy or limp when held, or didn't cuddle with you _____ | | | |
| Colicky _____ | | | |
| Hard to care for _____ | | | |
| Other _____ | | | |

DEVELOPMENTAL MILESTONES

1. **MOTOR MILESTONES AND DEVELOPMENT**

At what month or year of age did your child:

- Roll over _____
- Sit without support _____
- Crawl _____
- Stand holding on _____
- Walk holding on _____
- Walk well _____
- Skip _____
- Ride a tricycle _____
- Ride a bicycle _____

2. **SOCIAL MILESTONES AND DEVELOPMENT**

At what month or year of age did your child:

- Smile in response to another person _____
- Tell one person apart from another _____
- Become anxious and cry with strangers _____
- Become anxious or cry when placed in a strange environment
without his mother _____
- Play nursery games such as patty cake or bye-bye _____
- Play with dolls or stuffed animals _____
- Make up and act out stories _____
- Play along-side other children without interaction _____
- Play together in cooperation with other children _____

3. **SELF-HELP MILESTONES AND DEVELOPMENT**

At what month or year of age did your child:

- Drink from a cup (not a sippy cup) _____
- Eat from a spoon _____
- Dress without assistance _____
- Use toilet for urine _____
- Use toilet for stool _____
- Stay dry during the daytime _____
- Stay dry at night _____

4. **SPEECH AND LANGUAGE MILESTONES AND DEVELOPMENT**

At what month or year of age did your child:

- Make his first sounds _____
- Squeal, gurgle and coo _____
- Start babbling and running sounds together _____
- Say MaMa and DaDa with meaning _____
- Say first word with meaning (other than MaMa and DaDa) _____
- Say first phrase (e.g. "I want a cookie") _____
- Become easily understood by other _____

Did your child ever:	YES	NO	NOT SURE
Make strange sounds or use strange language _____			
Have any kind of speech impediment _____			
Require and/or receive speech therapy _____			
Have discontinuous language development _____			
Have language development stop or regress _____			
Often repeat words or phrases he has just learned instead of responding to what was just said or asked _____			
Use incorrect pronouns to refer to himself (e.g. "he" or "she" instead of "I" or "me") _____			
Use incorrect pronouns when referring to others _____			
Seldom or never begin a conversation with someone else (once he could speak) _____			
Only talk to himself, not others _____			

5. OTHER

	YES	NO	NOT SURE
Has anyone ever suggested your child might have a developmental delay?			
Has anyone ever suggested your child might be mentally handicapped or retarded? _____			
Is your child affectionate and cuddly? Will he sit near you or others?			
Will your child look at people, talk to them and interact with them the way you would expect him to? _____			
Has your child, or does your child, do any of the following;			
Body rocking _____			
Head banging _____			
Hand flapping _____			
Toe walking _____			
Make repetitive nonsense sounds when old enough to speak normally _____			

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S DEVELOPMENT OR DEVELOPMENTAL HISTORY?

YOUR CHILD'S SOCIAL HISTORY

1. Does your child prefer to play alone or with others? ALONE WITH OTHERS NOT SURE
2. Does your child have any good friends? YES NO NOT SURE
 If "yes":
 - a. Who are his/her closest friends?
 - b. What attracted your child to these friends?
 - c. What do they do together?
 - d. How often do they get together?
3. What are your child's hobbies?
4. a. What is your child best at doing?

- b. What is he/she least good at?
- 5. Does your child ever feel guilt or remorse for wrong doings? If "yes" how does he/she show it?
- 6. Does your child feel guilty even when what he/she has done isn't that terrible?
- 7. a. How well does your child seem to like him/herself?
b. What does he/she like best about him/herself?
- 8. Does your child make negative statements about him/herself? What are they?
- 9. Does your child feel like a "loser"?
- 10. Does your child get picked on or teased? If "yes",
a. What about or why?
b. How does he/she handle it?
- 11. How does your child handle peer pressure?
- 12. Who is your child most likely to confide in?
- 13. Which parent is your child closest to?
- 14. How does your child get along with Mom?
- 15. How does your child get along with Dad?
- 16. How does your child get along with siblings?

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S SOCIAL HISTORY?

SCHOOL HISTORY

WHICH SCHOOLS HAS YOUR CHILD ATTENDED?

Name of School	Grades Attended	Dates	Reason for Leaving	Type of Class

1. Describe your child's attitude toward school.

2. Describe your child's behavior in school.

3. Has your child ever refused to go to school? If "yes", please explain.

4. a. Which are his/her best subjects?

b. Which are his/her favorite subjects?

5. a. Which are his/her worst subjects?

b. Which are his/her least favorite subjects?

6. Have your child's grades changed over time? If "yes", please explain.

7. Has your child been tested for Learning Disabilities? If "yes", please describe the results.

8. Has your child had intellectual testing done? Please describe the results.
9. Has your child been held back or skipped a grade? Please explain.

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S SCHOOL HISTORY?

FAMILY SOCIAL HISTORY

1. Have there been any recent stresses in the family? Please explain.
2. Has anyone recently left the family or died? Please explain.
4. Has anyone recently joined the family? Please explain.
5. Have there been any recent employment changes or job losses? Please explain.
6. Have there been any recent financial changes (good or bad)? Please explain.
7. How many times has your family moved during your child's lifetime? Please explain your moves and reasons for moving. How did your child adapt to moving?

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR FAMILY?

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD?
