Children and Adolescent Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected and confidential information.

Personal Information

Name of Client: ____

Preferred Name: ____

Parent/Legal Guardian (if under 18): ____

Address____

Home Phone__________________________________ May we leave a message __Yes ___No

Cell/Work/Cell/Work/Another Phone: _______________________ May we leave a Message ___Yes __No

DOB: ____________________________ Age__________ Gender Preference: _______________

Emergency Contact: ______________________________ Relationship: _____________________________

Emergency Contact Phone____

Referred By (If Any) ____

How would You Describe your Sexual Orientation?
____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_________________________
Anxiety	yes / no	_________________________
Depression	yes / no	_________________________
Domestic Violence	yes / no	_________________________
Eating Disorders	yes / no	_________________________
Obsessive Compulsive Behavior	yes / no	_________________________
Schizophrenia	yes / no	_________________________
Suicide Attempts	yes / no	_________________________
Anger Issues	yes / no	_________________________

Mental Health Information

How would you rate your current physical Health? (Please Circle One)

Poor Unsatisfactory Satisfactory Good Very Good

Pleas List any Specific Health Problems you are currently experiencing____
____
____

How would you rate your current sleeping habits (Please Circle One)?

Poor Unsatisfactory Satisfactory Good Very Good

Please List any Specific Sleep Problems you are currently experiencing:____
____
____

How many times per week do you generally exercise/Participate in Extracurricular activities?____

Please List any difficulties you experience with your appetite or eating problems:____
____

School Information

Current School____Grade_________________________

School Contact____

Usual Grades:_______________________________ Has there been a change in grades in last 6months, Please
Explain:____
____

Does Child have an
IEP/504plan?_________________PleaseExplain____
____

Past History of Trauma (Physical, Sexual, Emotional Abuse) Yes or No, Please
Explain:____
____
____

Psychiatric History

Have you previously received any type of mental Health Services (Psychotherapy, Psychiatric Services, Etc.)? Yes or No

If Yes, previous Clinician:
____

Are you Currently taking prescription Medication? Yes or No_____________________________________

If yes, Please
List____
____

Have you ever had a psychiatric hospitalization? Yes or No________________________________

If yes, please provide dates and
reason____

Please Briefly Describe the problem(s) for which you are currently seeking help with:____
____
____
____

How long has the problem(s) existed? ____

Have you sought assistance with the problem(s) before Yes or No? Please Explain____
____

What else would you like me to know?____
____
____

I attest that all the information I have given above is accurate and complete to the best of my knowledge.

Authorized Signature_____________________________   Date _____________________________

Reviewed by Clinician: _____________________________ Date_______________________________