FOCUS CENTERS, PLLC

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Child Intake Questionnaire

Child's Name: _____ Age: _____Date: _____

Your Name(s):_____ Relationship to Child:_____

Presenting Problem and Prior Treatment

1. What is your major concern that led you to seek help?

_____

_____

_____

_____

_____

2. What other concerns do you have?

_____

_____

_____

_____

_____

3. Is there a particular reason you are seeking an appointment now?

_____

_____

_____

4. Has the child ever had a psychological evaluation or had intellectual or achievement testing at school?

No _____ Yes _____ If yes, describe when, with whom and what were the results.

_____

_____

_____

_____

_____

5. Has the child ever been in counseling, or have you ever sought help for these problems before?

No _____ Yes _____ If yes, enter the information below.

Date(s) and number of visits of **most recent counseling**:
Who did you see?
Explain what happened and the results:
Date(s) and number of visits of **any earlier counseling**:
Who did you see?
Explain what happened and the results:

6. Has the child ever taken medication for attention, behavior or mood problems? No ____Yes _____

If yes, carefully enter the following information for each medication in the columns below.

Medication			
Dose			
Reason prescribed			
Dates Taken			
Prescribing Physician			
Benefits			
Problems			
If discontinued, why?			

7. Has the child been to the doctor in the last year? No _____ Yes _____ If yes, were the current concerns discussed and if so, what recommendations were made?

_____

_____How is the child's current health? Is the child being treated for anything?

_____

_____

8. Is the child allergic to anything including medications? No _____ Yes _____ If yes, please describe.

_____

9. What medical or physical problems has the child had? Mark an *X* and then describe below.

	Birth to 5	6-12	13-18
Allergies or food sensitivities	_____	_____	_____
Ear infections, frequent colds	_____	_____	_____
Poisoning or drug overdose	_____	_____	_____
Serious illnesses or surgeries	_____	_____	_____
Vision or hearing difficulties	_____	_____	_____
Speech disorders	_____	_____	_____
Serious accidents/Injuries	_____	_____	_____
Any blows to the head or concussion	_____	_____	_____
Any loss of consciousness or seizures	_____	_____	_____

_____

_____

_____

10. Does the child get headaches? No _____Yes ____ If yes, please describe the type, frequency and severity?

_____

_____

11. List any medications the child <u>currently</u> taking for other health problems in the columns below.

Medication			
Dose			
Purpose			
Date Started			
Physician			
Side Effects			

12. Were there any problems or unusual circumstances during the pregnancy, delivery or first months of life?

    No _____ Yes _____ Don't know _____ If yes, please describe.

    _____

    _____

    _____

13. Was the child adopted? No _____ Yes _____ If yes, at what age? _____

14. As an infant, was the child difficult, demanding, hard to soothe, colic or have problems sleeping?

    No _____ Yes _____ Don't know _____ If yes, please describe.

    _____

    _____

    _____

15. Were there any disruption or major difficulties that could have affected the child's bonding with his or her mother during the first three years?

    No _____ Yes _____ Don't know _____ If yes, please describe.

    _____

    _____

    _____

16. Were there any developmental problems including delay in learning to crawl, walk or talk?

    No _____ Yes _____ Don't know _____ If yes, please describe.

    _____

    _____

    _____

17. As a child, was the child extremely physically active or always "on the go"?

    No _____ Yes _____ Don't know _____ If yes, please describe.

    _____

    _____

    _____

Psychosocial History Please describe any of the following the child has experienced.

Problem Areas	Age(s)	Nature of event and impact on child
Problems in family such as separation, divorce or remarriage of parent; psychiatric, alcohol or drug problems of parent or sibling, death or serious health problems of family member; change in living arrangements;		
Emotional, physical or sexual **abuse**; neglect, or exposure to domestic violence		

Social Relations

Problems in social network such as death or loss of close friends rejection by peers, or frequent moves causing loss of friends		
Educational problems including learning problems, problems with teachers or classmates, ridicule or bullying		
Problems with housing, living arrangements or sudden loss of family income, such as homelessness, frequent moves or suddenly not having family income		
Medical problems, illness or surgeries		
Problems related to the police, or interaction with the legal system, being a victim of a crime or a ward of the court		
Exposure to disaster, accidents or other trauma		

18. What are the child's current living arrangements? If the parents are divorced, who has custody and what are the visitation arrangements?

_____

_____

_____

_____ _____

19. How well does the child get along with his/her parents?

Mother/step-mother:_____

_____

Father/step-father:_____

_____

20. If the child is not living with both natural parents, what is his/her relationship with the non-custodial parents?

_____

_____

_____

21. If birth parents are not together, how well do they get along, especially in regards to the child?

_____

_____

_____

22. How well does the child get along with siblings?

_____

_____

_____

23. How well does the child get along with other friends and peers?

_____

_____

_____

24. Does your child have problems either understanding or expressing emotions? Does your child have problems with social awareness?

_____

_____

School History

25. What is your child's current grade? _____

26. What was the Grade Point Average on the most recent report card? _____

27. Is your child currently on an Individualized Education Plan (IEP), and if so, for what problem areas?

_____

28. Please mark with an "X" when any of the following has been serious problem.

	Preschool/Kindergarten	Elementary School	Middle School	High School
Reading difficulties	_____	_____	_____	_____
Math difficulties	_____	_____	_____	_____
Writing difficulties	_____	_____	_____	_____
Poor grades	_____	_____	_____	_____
Homework problems	_____	_____	_____	_____
Behavior problems at school	_____	_____	_____	_____
Peer Problems	_____	_____	_____	_____
Hating school	_____	_____	_____	_____
Resource or special educations classes	_____	_____	_____	_____
After-school or summer tutoring	_____	_____	_____	_____

29. What things have you tried at home to solve any of the problems noted above?

_____

_____

_____

30. Please circle any of the following that are <u>current</u> problems:

Reading problems marked by difficulty sounding out words, guessing at words or reading smoothly

Problems tracking while reading (losing place, missing words, complaining of headaches or eyes hurting

Difficulty remembering what was read

Difficulty with math calculations

Difficulty understanding math concepts

Difficulty at written composition

Difficulty spelling

Poor handwriting (even if writing slowly)

Difficulty drawing or copying figures

Poor sense of direction

Poor balance or coordination

31. Please describe your child's greatest strengths and any special abilities or talents. In what school subjects has he or she generally done best?

_____

_____

_____

Attention Problems

32. What problems, if any does the child have with daydreaming, staying on-task or being disorganized? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places?

_____

_____

_____

33. What problems, if any does the child have with hyperactivity, stimulus seeking or feeling restless? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places?

_____

_____

_____

34. What problems, if any does the child have with impulsivity or acting without thinking of consequences? At what age did you first notice this? Do the problems occur mainly at home, at school or in both places?

_____

_____

_____

Oppositionality, Anger and Conduct Problems

35. How cooperative is the child? If asked to do 10 things during a day, how many would they do correctly on the first request, without arguing or delaying? _____ How much do you feel the problem is with being defiant and uncooperative versus distractible or disorganized?

_____

_____

_____

_____

36. What problems, if any does the child have with irritability and anger? When angry, is the child more likely to let the anger go quickly or hold onto resentment?

_____

_____

_____

_____

37. Does the child ever become violent or destructive? Have they ever hurt anyone intentionally or threatened to kill someone? Have they ever been cruel to animals? What interest does the child have in weapons?

_____

_____

_____

38. What problems, if any, does the child have with authority or with getting into trouble, unlawful activity or delinquent actions that could cause legal consequences?

_____

_____

_____

39. In relating to others, what problems, if any, does your child have in terms of lacking empathy, being manipulative or failing to show remorse when appropriate?

_____

_____

_____ _____

Depression

40. What problems does your child have with their feeling being too easily hurt? Are there any signs of problems with self-esteem? Are there particular things about him or her self your child feels bad about?

_____

_____

_____

_____ _____

41. What problems, if any, does the child have with sadness, moodiness, withdrawing from friends or activities, looking unhappy, crying easily, or other signs of depression?

_____

_____

_____

_____ _____

42. Has the child ever talked about wishing they were dead or discussed or attempted suicide?

_____

_____

_____

Anxiety

43. What problems, if any, does the child have with fears, tension, anxiety, panic attacks, phobias, being very uncomfortable in new situations or extreme shyness? How has that changed over time?

_____

_____

_____ _____

_____

44. How likely is the child to complain of not feeling well that may be related to stress or anxiety?

_____

_____

_____

_____ _____

45. Does the child show intense fear; helplessness, upset or avoidance around anything that reminds them of any trauma such as having been a victim of, or witness to, violence, or having been in an accident?

No _____ Yes _____ if yes, please describe

_____

_____

_____

_____ _____

46. Are there any ideas, fears or concerns about which the child obsesses or worries?

_____

_____

_____

47. Does the child have any habits, rituals or other compulsive behaviors?

_____

_____

_____

48. What problems does the child have with muscle or verbal tics? These are repetitive movements or noises such as eye blinking, facial twitching, or noises such as grunting, snorting, squeaking, or humming.

_____

_____

_____

Substance Use

49. Does the child use tobacco or tried to smoke? Yes _____ No _____

50. Does the child drink coffee? How much other caffeinated beverages do they drink?

_____

_____

51. Do you have any knowledge or suspicion that the child has drank alcohol? If so describe.

_____

_____

_____

52. Do you have any knowledge or suspicion that the child has used drugs? If so describe.

_____

_____

_____

Other Health Related Matters

53. What problems, if any, has the child had with eating, sugar cravings, dieting or maintaining weight? How healthy an eater is the child? Has the child ever been tried on any special diets?

_____

_____

_____

54. How much activity or physical exercise does the child get?

_____

_____

_____

_____ _____

55. (Adolescent females only) what problems, if any does the child have with unusual depression, irritability or discomfort during the week or so before the menstrual period?

_____

_____

_____

56. Please circle any of the following sleep problems that your child has and then describe the severity or frequency in the space below:

Difficulty waking in morning	Frequent waking during night	Teeth grinding
Difficulty falling asleep	Nightmares (bad dreams)	Snoring
Not rested after sleep	Sleeping too much	Bed-wetting
Physically restless sleep		Delays going to bed

_____

_____

_____

_____ _____

57. Anything else it would be helpful to know about?

_____

_____

_____

_____ _____

_____

_____

_____

_____ _____

Family History

58. For each of the following, please identify any relatives (siblings, parents, grandparents, aunts or uncles) who may have had problems in these areas (i.e. "One of Mom's sisters took medication for depression.", "One of Dad's brother drank heavily from age 15 to 40 and then went into treatment").

Check here if father's family history is unknown. ( ) Check here if mother's family history is unknown. ( )

Problems with attention including being distractible, hyperactive or impulsive.

Problems in school or problems learning to read, write or do math.

Problems with opposionality, anger, violence or criminal behavior

Depression or Anxiety

Headaches/migraines/ seizures/neurological problems

Alcohol Problems
Drug abuse

Serious health problems

Other mental or emotional illness

Thank you for completing this form!