Midwest Center for Human Services, L.L.P.

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Child/Adolescent Intake Questionnaire

Referred by: _____ Today's date: _____

The following are questions asked of all children and adolescents beginning services at Midwest. The information you provide will assist your therapist in getting to know you/your child as quickly as possible. Please answer all questions as completely as possible. Your answers are confidential and will not be shared with anyone outside the clinic without your written consent.

Child's Name: _____ DOB: _____ SS#: _____

Address: _____ Religion: _____

_____ Phone: __(___)_____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

_____ _____

Phone: Home __(___)_____ Phone: Home __(___)_____

Work __(___)_____ Work __(___)_____

Parents' ethnic identity(ies): _____

Others in the household/family:

Name	Relationship	Age	Educ/Occup/Location

Have there been any changes in your family within the past year? Yes: _____ No: _____

Has anybody in your immediate or extended family had emotional problems? Yes: _____ No: _____

Has anybody in your immediate or extended family had learning problems? Yes: _____ No: _____

Has anybody in your immediate or extended family had difficulties with alcohol and/or other drugs? Yes: _____ No: _____

Has your child had a significant period of separation from parents or family? Yes: _____ No: _____

If so, why and when?

_____

_____

_____

_____

_____

_____

EDUCATION

Current grade: _____ Current school: _____

Favorite subjects: _____

Least favorite subjects: _____

How many schools has your child attended? _____

Has your child received any testing or counseling in school? Yes: _____ No: _____

How does your child get along with classmates? _____

How does your child get along with teachers? _____

HEALTH

Were there any problems during pregnancy or delivery? Yes: _____ No: _____

Describe your child's personality/temperament during infancy: _____

_____

At what age did your child first walk? _____

.....use single words? _____

.....speak in 3-4 word sentences? _____

.....toilet train? _____

Has your child had any significant surgeries or hospitalizations? Yes: _____ No: _____

Current health/medical problems: _____

Current physical symptoms: _____

Date of last physical exam: _____ Reason? _____

Current medications (name, dosage): _____

Current Physician (include address): _____

Has your child ever experienced the following? (if yes, please list by whom and when)

Physical abuse? _____

Verbal/emotional abuse? _____

Neglect? _____

Incest? _____

Sexual assault? _____

Other (describe)? _____

Circle if your child has experienced any of the following major changes in the past year:

Concentration Appetite Sleep Friendships Move Behavior

Death in family Parental divorce / separation Other _____

PREVIOUS TREATMENT

Has your child received any psychotherapy services previously? Yes: _____ No: _____

If so, please list therapist(s) name/location/dates: _____

_____

Have there been any psychiatric /alcohol / drug abuse hospitalizations? Yes: _____ No: _____

If so, please indicate when and where: _____

What are your child's strengths? _____

_____

_____

_____

Please briefly describe the problems which you/your child is experiencing. Begin with the problem which seems most important to work on.

Problem #1: _____

What would be the best outcome?

_____

_____

What would be the worst outcome?

_____

_____

_____

Problem #2: _____

What would be the best outcome?

_____

_____

What would be the worst outcome?

_____

_____

_____

Problem #3: _____

What would be the best outcome?

_____

_____

What would be the worst outcome?

_____

_____

Is there additional information that would be helpful in working with you/your child? _____

_____

_____

_____

_____

_____