Child Intake Questionnaire

Treatment Goals:

Why are you seeking counseling for your child?

What changes do you hope to see in your child?

Schooling Information:

What does your child's teacher say about him/her?

Has your child ever repeated a grade?

Has your child ever received special education services?

Has your child experienced any of the following problems at school?

Fighting Lack of friends Detention Suspension Learning disabilities

Poor attendance Poor grades Incomplete homework Behavior problems

Health Information

Has your child experienced any of the following medical problems?

A serious accident Hospitalization Surgery Asthma A head injury

High fever Convulsions / seizures Eye / ear problems Meningitis

Hearing problems Allergies Loss of consciousness Other

Please list any current medical problems or physical handicaps:

OVER

Please list any medications your child takes on a regular basis:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy?

Did the child's mother have any problems during the pregnancy or at delivery?

Has your child ever experienced any type of abuse (physical, sexual or verbal)?

Has your child ever made statements of wanting to hurt him/herself or seriously hurt another?

Has he/she ever purposely hurt himself or another?

Has your child ever experienced any serious emotional losses (such as death of or physical separation from a parent or other caretaker)?

What are some of the things that are currently stressful to your child and his/her family?

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol?

Is there anything else you'd like me to know?

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