Calming Journeys Counseling, S.C.

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INTAKE QUESTIONNAIRE – CHILD

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: ________________________________ Date: ______________________

Child is my: __ biological child __ adopted child __ foster child Other: ____________________

IDENTIFYING INFORMATION (for individual receiving services)

Child's Name: ______________________________ Date of Birth: ______________________

Preferred Name: ______________________________ Pronouns: He/Him, She/Her, They/Them, Other: ____________________________________

Preferred Phone Number: ____________________ Cell Phone: ________________________

Who referred you to Calming Journeys Counseling, S.C. : ____________________________________

Child's Race:

- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Child's Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic or Non-Latino
- ☐ Latino
- ☐ Other: ____________________

Child's Language of Choice:

- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: ________________________________

Family's Religious Affiliation:

- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: ________________________________

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: ______________________________
If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: ____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

____

____

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

a. Behavior at home	g. Overactivity	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Relationship
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior at school	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. School performance	r. Other (explain):

____

____

2. How long has the child had this/these problem(s)? ________________________________

3. Has the child received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

   If yes when, where and with whom? ______________________________________

SUICIDE RISK

Has your child ever expressed suicidal thoughts? If yes, please describe.

____

____

Has your child ever self-harmed or attempted suicide? If yes, please describe.

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____

Has your child ever been a danger to someone else? If yes, please describe.

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Current/Recent Suicide

Risk:____

____

____

FAMILY HISTORY

1. With whom does the child currently live (names and relationship)? ____________________

   Has the child lived with anyone else in the past? ☐ Yes ☐ No With whom? ____________

2. Please provide the following information about the child (as applicable):

Father's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

Mother's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

Stepfather's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

Stepmother's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

Foster Father's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

Foster Mother's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

Guardian/Other's Name: ______________________ Phone #: ______________

Address: ____

D.O.B.: __________ Occupation: __________ Education: ______________

3. Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (full, half, step, foster)	Lives with Child?	If no, lives where?
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	

4. Does the child or any other family member have a history of alcohol or drug problems? ☐ Yes ☐ No

If yes, please explain: ____

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5. Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? ☐ Yes ☐ No If yes, please describe the circumstances: ____________________

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LEGAL HISTORY

Please describe any involvement the child has had with the legal system (arrests, convictions, probation, parole):

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DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal? ☐ Yes ☐ No ☐ I don't know

If no, please explain: ____

2. Did mother use alcohol or other drugs during pregnancy? ☐ Yes ☐ No ☐ I don't know

If yes, please explain: ____

3. Please list any medications taken during pregnancy: ______________________________________

4. Did the child reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained - night				

MEDICAL HISTORY

1. Primary Care physician/pediatrician: ____

2. Would you like Calming Journeys Counseling to coordinate care with your PCP? ☐ Yes ☐ No
If yes, you will need to fill out a release of information for your PCP.

3. Please check the appropriate box if the child has experienced any of these problems:

- ☐ Eye disease, injury, poor vision
- ☐ Ear disease, injury, poor hearing
- ☐ Nose, sinus, mouth, throat problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Thyroid disease or goiter
- ☐ Skin disease
- ☐ Heart disease
- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Cancer
- ☐ Bowel problems
- ☐ Hemorrhoids, rectal bleeding
- ☐ Loss of consciousness
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Allergies or asthma
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy
- ☐ High blood pressure
- ☐ Other

Please explain anything checked above: ____

____

3. Please provide information about medication(s), prescription or over-the-counter, which the child takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): ______________

____

SCHOOL INFORMATION

1. What school does the child currently attend? ________________________________

2. What is the child's teacher's name? ______________________________________

3. What grade is the child in? ____

4. How many schools has the child attended? _________________________________

   In which cities/towns were they located? ___________________________________

5. Does the child have a written IEP? ☐ Yes ☐ No

   Is the child in special education classes? ☐ Yes ☐ No Type: ____________________

6. Is the child experiencing any problems in school?

Academics (grades): ☐ Yes ☐ No

Behavior: ☐ Yes ☐ No

Social (peers or adults): ☐ Yes ☐ No

Please explain any "yes" responses: ______________________________

____

SOCIAL RELATIONSHIPS / FRIENDS

1. How does the child get along with peers? ______________________________

____

____

2. How does the child get along with adults? ______________________________

____

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3. Does the child spend more time with (check the closest answer):

☐ Same age children ☐ Adults

☐ Older children ☐ Mostly alone

☐ Younger children

4. What are the child's hobbies and interests? ______________________________

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____

HOME LIFE

1. Is there a behavior problem at home? ☐ Yes ☐ No If yes, please explain: ______________

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2. What are the child's strengths? ______________________________

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3. What are the family's strengths? ______________________________

____

4. What are the child's weaknesses? ______________________________

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5. What are the family's weaknesses? ______________________________

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6. What kind of discipline is used with the child? ______________________________

Who is the primary disciplinarian? ______________________________

7. Are there any family circumstances you would like us to be aware of? ______________________________

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8. What goals would you like to see reached as a result of your child's involvement with Calming Journeys Counseling, S.C.?

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9. How will you know when these goals have been reached (describe changes in behavior or functioning)?

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THERAPIST REVIEW

Signature: ______________________________ Date: ______________________