CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

Thomas Joseph Doherty, Psy.D, Licensed Psychologist

Client Name: _____ Today's Date: _____

First Middle Last

Gender: M __ F __ Age: _____ Ethnicity: _____ Birth Date: _____ SSN: _____

Parents/ Guardians: 1. _____ 2. _____

Relationship: _____ _____

Address: _____ _____

City, State, Zip: _____

Telephone(s): _____ _____ _____

(home) (cell) (work)

e-mail: (1) _____ (2) _____

May we leave messages for you? □ home phone □ work phone □ email □ other _____ □ No

Parents/ Guardians: 3. _____ 4. _____

Relationship: _____ _____

Address: _____ _____

City, State, Zip: _____

Telephone(s): _____ _____ _____

(home) (cell) (work)

e-mail: (1) _____ (2) _____

May we leave messages for you? □ home phone □ work phone □ email □ other _____ □ No

□ Others living in the home or siblings outside home

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

Emergency contact: _____ Phone: _____ Relationship: _____

Referred by: _____

	Education	Occupation	Employer
Parent 1			
Parent 2			
Parent 3			
Parent 4			

Client Name:
STRENGTHS & ISSUES
What are your child's strengths and unique abilities? What is going well in your child's life?
Describe the issues or problem(s) that brought you here today:
When did these problems begin?
How does the family-as-a-whole function?
Current School: _____ Describe your child's academic ability & performance?
Describe the relationship and level of collaboration of parents or care-givers:
What are your goals for this visit?
Is there any other information that may be helpful (for example, ethnic or other diversity, spirituality, health issues, etc.)?

Check any of the symptoms that your child is having:			
	Depression		Feeling of extreme happiness
	Extreme sadness		School Problems
	Trouble concentrating		Problems getting along with friends or family
	Memory problems		Cold / Flu
	Feeling hopeless		Injuries
	Lack of energy		Chronic Health Conditions
	Feeling tearful		Physical complaints of pain
	Lack of enjoyment of usual activities		Change in sexual interest or function
	Change in eating habits		Disordered Eating
	Change in sleeping habits		Weight changes
	Loss or Grief		Substance Abuse
	Self-esteem problems		Feeling stressed
	Perfectionism		Easily irritated
	Feeling fearful		Problems with anger
	Feeling guilty		Acting violently
	Feeling nervous		Legal Problems
	Obsessions or compulsions		Thoughts of hurting self or others
	Feelings of panic		Thoughts of killing self or others

MEDICAL INFORMATION

Has your child seen a doctor within the last year? Yes [ ] No [ ]	
Why did they see a doctor?	
Who is your doctor? Phone:	
Is your child taking any medications, prescription or over-the-counter? Yes [ ] No [ ]	
Medications	Dosages
1.	
2.	
3.	
4.	
Does your child have allergies to anything? Yes [ ] No [ ]	
Please describe allergy problems that they have:	

HAS YOUR CHILD OR FAMILY EVER BEEN IN COUNSELING BEFORE? Yes [ ] No [ ]
If yes, please describe counseling below. Start with the most recent time first.

A. Date(s):	
Name of provider:	
Explain what happened:	

B. Date(s):	
Name of provider:	
Explain what happened:	

C. Date(s):	
Name of provider:	
Explain what happened:	

SUBSTANCE USE HISTORY			
Does your child use/ have they used tobacco (any form)?	Current [ ]	Past [ ]	No [ ]
Does your child use/ have they used alcohol?	Current [ ]	Past [ ]	No [ ]
Does your child use/ have they used caffeine (any form, including cola drinks)?	Current [ ]	Past [ ]	No [ ]
Does your child use/ have they used other mind-altering substances (drugs)? Please Describe:	Current [ ]	Past [ ]	No [ ]

IF THERE IS OTHER INFORMATION YOU THINK IS IMPORTANT, PLEASE ATTACH ADDITIONAL SHEETS