Quince Orchard Psychotherapy
Initial Intake Form
Child/Adolescent Parent Questionnaire

A. Identifications

1. Child's name: _____ Birthdate: _____Age: _____
Person(s) completing this form: _____ Today's date: _____

2. Mother's name: _____ Age: _____Primary phone #: _____
Address: _____
Highest school grade completed?_____Occupation: _____
Work phone: _____ Email address:_____

3. Father's name: _____ Age: _____Primary phone #: _____
Address: _____
Highest school grade completed?_____Occupation: _____
Work phone: _____ Email address:_____

4. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other: _____

***Are there any legal custody arrangements between the patient's parents/legal guardians?_____**
If yes;

1. **Please provide all documentation concerning custody and legal authorization to consent to mental health treatment and/or testing.**
2. **If only one parent has legal authority to consent to treatment, please provide all relevant documentation.**
3. **If both parents agree to this patient (under 16 years old), then <u>both parents</u> must sign and acknowledge the <u>Informed Consent Form and Practice Policies Form</u>.**

5. Step-parent's name (if applicable): _____ Age: _____
Primary phone #:_____ Address: _____
Highest school grade completed?_____Occupation: _____
Work phone: _____ Email address:_____

6. Is your child/teen adopted?_____ If so, at what age?_____
What is known about the child's biological parents?_____

7. Who else lives in the child's home? (please include names and ages of siblings)
_____
_____

8. Religious denomination/affiliation (specify, if applicable): _____
Involvement: ❑ None ❑ Some/irregular ❑ Active

9. Ethnicity/national origin: _____
Other important identifiers: _____

B. Referral: How did you find out about my practice?_____

C. Medical care: From whom or where does your child receive medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
May I contact your child's medical doctor so that he or she can be fully informed and we can coordinate treatment?
❑ Yes ❑ No

Health Insurance Information (I will need to make a copy of your card(s))

Name of Primary insurance company:_____
Primary Subscriber's Name, Date of Birth, and Address:_____
Member ID number:_____ Group number (if applicable):_____

Name of Secondary insurance company:_____
Primary Subscriber's Name, Date of Birth, and Address:_____
Member ID number:_____ Group number (if applicable):_____

D. Emergency information
If some kind of emergency arises and I cannot reach you directly, whom should I call?
Name: _____ Phone: _____ Relationship: _____
Address: _____

E. Chief concern
Please describe the main difficulty that has brought your family to see me. How long has it persisted?
_____
_____
_____

F. Prior Treatment
1. Has your child ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
❑ No ❑ Yes If yes, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____

2. What medication(s) is your child currently taking? If applicable, please indicate the medication, the dosage, and the prescribing physician:_____

What medication(s) has your child taken in the past?:_____

3. Has your child ever received psychological testing? If so, whom may I contact for a copy of the report?_____
_____

G. Developmental History

1. Pregnancy and delivery
Prenatal medical illnesses and health care: _____
_____
_____
Length of pregnancy:_____ Birthweight:_____
Any birth complications or problems? _____
_____

2. The first few months of life
Breast-fed? If so, for how long? _____
_____
Feeding and Sleep patterns or problems: _____
_____
Personality/Temperament:_____

3. Milestones: At what age did your child do each of these (approximately)?

Crawled: _____ Walked without holding on: _____ Spoke first word: _____
Toilet trained: _____

Any speech, hearing, language, or motor difficulties? _____
_____

H. Health

List all childhood illnesses, hospitalizations, medications, allergies, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(list more on the back of this page if necessary)

Is there a family history of any medical or mental health problems? Please describe:_____
_____
_____

Has the child been exposed to traumatic events (the loss of a loved one, a natural disaster, etc.) or been subject to abuse or neglect (physical, verbal, sexual, or emotional)? Please describe:_____
_____

I. Residences

Has the child moved multiple times? How did they respond? _____
_____

Please list the names and dates of any institutional placements or foster care _____
_____

J. Schools

School name	Dates attended	Academic Performance	Problem areas?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(list more on the back of this page if necessary)

May I call and discuss your child with the current teacher? ❑ Yes ❑ No

If so, what is the teacher's name and phone number?: _____
_____

Does your child have an Individualized Education Plan (IEP) for special education purposes? If so, whom may I contact to obtain a copy?_____

Please describe any learning problems:_____
_____

Has your child ever repeated a grade?_____

K. Unique attributes of child
List hobbies, sports, recreational, musical, TV, and toy preferences, etc.: _____
_____
_____
What do you see as being your child's strengths and weaknesses?_____
_____
_____

L. Relationships
Please briefly characterize how your child gets along with:
Parents:_____
_____
_____
Siblings: _____
_____
_____
Peers: _____
_____
_____
Other important relationships (extended family, nanny, boyfriend/girlfriend, etc.): _____
_____
_____

Are there any stressful events occurring in the family that could be affecting the child?_____
_____

M. Risk taking
Does your child have a history of impulsive behaviors such as lying, stealing, using drugs or alcohol, fighting, engaging in promiscuous sex, etc.? If so, have they had any serious consequences (suspension from school, legal involvement, etc.)?:_____
_____

How do you reward and discipline your child?_____
_____

N. Other
Is there anything else I should know about that does not appear on this form and that might be important?
_____
_____
_____