Quince Orchard Psychotherapy

Compassionate, Client-centered Care

Rockville
9707 Key West Avenue, Suite 100
Rockville, MD 20850

Frederick
10 N. Jefferson Street, Suite 202
Frederick, MD 21701

P: (240) 750-6467; F: (240) 912-7835; Web: www.QOpsych.com

Initial Intake Form
Child/Adolescent Parent Questionnaire

1. Child's name: _____ Preferred name:_____
Birth date: _____Age: _____Preferred pronoun:_____ Preferred gender:_____
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;
Please provide all documentation concerning custody and legal authorization to consent to mental health treatment and/or testing.

If only one parent has legal authority to consent to treatment, please provide all relevant documentation. If both parents agree to this patient (under 16 years old), then both parents must sign and acknowledge the Informed Consent Form and Practice Policies Form.

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? With what results?		For what?
_____	_____	_____	_____
_____	_____	_____	_____

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?
_____
_____
_____
_____

CHILD-INFORMED CONSENT

I will keep confidential from outside parties anything you or your child says to me with the following exceptions:

-I determine the child is a danger to himself/herself or others (but I will make every effort to include you in this determination);

-Child, elder, or dependent person abuse reporting as mandated by law;

-I am ordered by a court to disclose information (this includes the possibility in child custody situations or litigation);

-If legitimate fee collection efforts become necessary;

-HIV status may need to be disclosed to an unknowing spouse or partner as mandated by law;

-You direct me to tell someone else by signing a release of information form. This includes releases you sign with an insurance company which are activated once you apply for reimbursement. This also includes a mental disorder diagnosis that I place on a bill submitted to insurance for reimbursement. In situations of voluntary disclosure to a third party to assist in your child's care, parents/caregivers can limit what is disclosed.

In the event I feel I need to consult with another professional in order to provide for your needs, I will do so, but only in a professional manner. Your identity will be kept anonymous. I will use the same guidelines as above to maintain confidentiality. Tell me if this is a concern.

I certify that I have read and accept the included brochure about my clinician's policies and procedures. I understand that it is my responsibility to ask any questions that I may have of my clinician before signing. I understand that we will now begin with an assessment of my needs and that neither the clinician nor I are under any obligation to continue with treatment from that point. I further understand that mental health is not an exact science and that no guarantee can be made as to the result or success of my treatment. I understand that treatment often involves making significant changes and that every change potentially has both positive and negative effects. I understand the potential benefits and risks involved in seeking mental health treatment and am willing to proceed at this time. I understand that I can discuss any questions or concerns that I have with my clinician at any point.

_____ _____

Signature of Parent/Legal Guardian (1) of a minor Date

_____ _____

Signature of Parent/Legal Guardian (2) of a minor Date

_____ _____

Therapist Date