

Western New York Psychotherapy Services

Child Intake Questionnaire

Parent/Guardian to fill out pertaining to children 17 years and younger or if the patient still lives at home.
Please complete this questionnaire about your son or daughter as accurately and completely as possible

GENERAL INFORMATION

Child's Name: _____

Date of Birth: ____/____/____ Age: _____ Gender: _____

Your Name: _____ Relationship to the Child: _____

Address _____

City _____ State _____ Zip Code _____

Phone Number (Day): _____ Phone Number (Evening): _____

Primary Care Physician: _____ Phone Number: _____

Address: _____

FAMILY INFORMATION

Please list all of the significant parental figures in the child's life

Name	Age	Gender	Relationship to the Child	Highest Level of Education	Occupation	Contact Phone #

Marital Status of the child's biological parents:

- Single Married Separated Divorced Remarried Living together Other: _____

If married, date of marriage: _____

*If divorced, date of divorce: _____

*If divorced or separated a copy of the custody agreement must be provided

If biological parents are divorced, who has legal custody of the child?

Please describe the custody arrangements:

Number of previous marriages & length of, mother: _____

Number of previous marriages & length of, father: _____

Did you adopt this child? Yes No If Yes, how old was the child when adopted? _____

Please list all mental health services that your child has received:

Dates	Reason	Therapist/Psychologist

Please list all psychological or psychiatric hospitalizations that your child received:

Dates	Reason	Hospital

Please list any prescription medications that your child is currently taking:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				School Days 7 Days As Needed	
				School Days 7 Days As Needed	
				School Days 7 Days As Needed	
				School Days 7 Days As Needed	
				School Days 7 Days As Needed	

Please describe you child's medication compliance:

Please describe any side effects from the medications:

Date of last physical: _____

CURRENT REASONS for SEEKING TREATMENT:

Please describe the reasons that you are seeking treatment for your child at this time:

Please briefly describe the history of these concerns and list all factors that may trigger or intensify these concerns:

Does your child have a history of being physically or verbally assaultive to others?

Describe any concerns that you have about you child's use of alcohol, drugs and/or tobacco products:

Please list the things you have tried/done to help your child:

Please describe your child's strengths:

To your knowledge, has your child ever had any of the following?

Diagnosis or Problem	Yes	No	Person who told you this and their position (ex. 3 rd grade teach, physician, self). Do not include names.
Aggression			
Alternating Mania and Depression (Bipolar)			
Anxiety			
Attention Deficit Hyperactivity Disorder			
Autism			
Behavior or Discipline Problems at School			
Conduct Disorder			
Depression			
Emotional Disturbance			
Hospitalized for Emotional Problems			
Jail or Probation Due to Problems w/ the Law			
Learning Disability or Dyslexia			
Learning Problems at School			
Mental Retardation			
Muscle Twitches or Motor Tics			
Nervous Breakdown			
Obsessive Thoughts or Compulsive Actions			
Oppositional Defiant Disorder			
Problems with Alcohol Use or Abuse			
Problems with Drug Use or Abuse			
Schizophrenia			
Suicide			
Tourette's Syndrome			
Trouble with the Law			
Other Psychological/ Behavioral Problems*			

EDUCATION

School Name:

Your child's current grade in school: _____ Typical Grades: _____

Has your child ever been held back in school?
If so, please describe the circumstances:

Has your child ever been suspended or expelled?
If so, please describe the circumstances:

Has your child ever been tested for intellectual ability or had any other psychological testing?
If so, what was the most recent date of testing? (Please provide copies of any previous testing)

Please describe the results:

Does your child have a 504 Plan?
If so, please describe the nature of the accommodations:

Does your child receive special education services?
If so, please describe the nature of the services received:

Does your child's teacher have concerns about your child?
If so, please describe:

Is your child currently participating in a school/classroom intervention?
If so, please describe:

Please list any concerns that you have for your child related to school:

PARENT DBD RATING SCALE

Check the column that best describes this child.

Please write "DK" next to any items for which you don't know the answer.

	Not at All	Just a Little	Pretty Much	Very Much
1. often intrudes on others (e.g. butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e. "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g. shoplifting, but without breaking and entering, forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill seeking), e.g. runs into the street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in her or her household (e.g. peers at school or in the neighborhood)				
21. often shifts from one uncompleted task to another				
22. often has difficulty playing or engaging in leisure activity quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities				
24. is often angry and resentful				

PARENT DBD RATING SCALE (CONT'D)

	Not at All	Just a Little	Pretty Much	Very Much
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				
34. often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g. mugging, purse snatching, extortion, armed robbery)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife, gun)				

INSTRUCTIONS: In the spaces below complete the rating at the end of each by marking an "X" on the lines at the points that describe how much your child's current challenges affect each area and *whether you need treatment or special services for the challenges.*

1a. How your child's challenges affect his/her relationship with friends?	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.

1b.. How your child's challenges affect his/her relationship with brothers or sisters? (if no siblings, check here _____ and skip to #2)	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.

2.. How your child's challenges affect their relationship with you?	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.

3. How your child's challenges affect their academic progress at school	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.

4. How your child's challenges affect their self-esteem.	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.

5. How your child's challenges affect your family in general	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.

6. Overall severity of your child's challenges in functioning and overall need for treatment	
No Problem _____ Definitely does not need treatment or special services.	Extreme Problem _____ Definitely needs treatment or special services.