Child Intake Questionnaire

Name: _____

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

_____
_____
_____

What are your goals for counseling?

_____
_____
_____

Has your child seen a mental health professional before? If so, please identify the clinician name or agency. When, for how long, and what was your child being seen for?

_____
_____
_____

Specify all medications and supplements your child is presently taking and for what reason.

_____
_____

If taking prescription medication, who is the prescribing MD? Please include MD name, specialty, and phone number.

_____
_____

Who is your child's primary care physician? Please include phone number.

_____

Is there a history of mental illness in the child's family? If so, please list below.

_____
_____
_____

Describe your child's current living situation. Who lives in the home and what is the relationship of each person to your child?

_____
_____

Current Family and Significant Relationships

Strengths/Supports:

_____
_____

Stressors/Problems:

_____
_____

Recent changes:

_____
_____

Changes desired:

_____
_____

Comments on family circumstances:

_____
_____

Childhood Developmental Milestones – Please circle answer

Did your child meet these developmental milestones on time?

Eating: ___Yes ___No

Crawling: ___Yes ___No

Talking: ___Yes ___No

Walking: ___Yes ___No

Toilet training: ___Yes ___No

Social connections: ___Yes ___No

Does your child have any history of medical related conditions? If so, please explain.

_____
_____

Does your child have any allergies? If so, please identify.

_____
_____

Does your child attend a school or daycare? If so, please identify.

_____
_____

Has your child experienced or been witness to any traumatic events? A traumatic event can be anything bad/scary/or out of your control that leaves you feeling helpless/hopeless/or powerless. Some examples can be but are not limited to: physical/sexual/emotional abuse, neglect, extreme poverty, witness to domestic violence, substance abuse by a caregiver, abandonment, divorce/separation, bullying, victim to a crime, natural disaster, car accident, etc.

_____
_____
_____

Is there anything else I should know to best help you and your child?

_____
_____
_____

Legal

Who is the child's legal guardian? Name and relationship.

_____

Does the legal guardian share custody with anyone? If so, please identify name and relationship to the child.

_____

Is there a custody agreement in place? If so, is the legal guardian able to provide a copy of the custody agreement?

_____

FORM A

Child's Name: _____ Date of Birth: _____

Filled out by: _____ Today's Date: _____

Pediatric Symptom Checklist 17 (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

	Please mark under the heading that best describes your child:	**Never**	**Sometimes**	**Often**
◆	**Fidgety, unable to sit still**	**0** ☐	**1** ☐	**2** ☐
■	**Feels sad, unhappy**	**0** ☐	**1** ☐	**2** ☐
◆	**Daydreams too much**	**0** ☐	**1** ☐	**2** ☐
●	**Refuses to share**	**0** ☐	**1** ☐	**2** ☐
●	**Does not understand other people's feelings**	**0** ☐	**1** ☐	**2** ☐
■	**Feels hopeless**	**0** ☐	**1** ☐	**2** ☐
◆	**Has trouble concentrating**	**0** ☐	**1** ☐	**2** ☐
●	**Fights with other children**	**0** ☐	**1** ☐	**2** ☐
■	**Is down on him or her self**	**0** ☐	**1** ☐	**2** ☐
●	**Blames others for his or her troubles**	**0** ☐	**1** ☐	**2** ☐
■	**Seems to have less fun**	**0** ☐	**1** ☐	**2** ☐
●	**Does not listen to rules**	**0** ☐	**1** ☐	**2** ☐
◆	**Acts as if driven by a motor**	**0** ☐	**1** ☐	**2** ☐
●	**Teases others**	**0** ☐	**1** ☐	**2** ☐
■	**Worries a lot**	**0** ☐	**1** ☐	**2** ☐
●	**Takes things that do not belong to him or her**	**0** ☐	**1** ☐	**2** ☐
◆	**Distracted easily**	**0** ☐	**1** ☐	**2** ☐

For Office Use Only:

Total ◆ _____ Total ● _____ Total ■ _____ ◆ + ● + ■ _____

Child and Adolescent Trauma Screen-Caregiver (CATS-C) - 7-17 Years

Name_____ Date_____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark No if it didn't happen to the child.

1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes ☐ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes ☐ No
3.	Robbed by threat, force or weapon	☐ Yes ☐ No
4.	Slapped, punched, or beat up in your family	☐ Yes ☐ No
5.	Slapped, punched, or beat up by someone not in the family	☐ Yes ☐ No
6.	Seeing someone in the family get slapped, punched or beat up.	☐ Yes ☐ No
7.	Seeing someone in the community get slapped, punched	☐ Yes ☐ No
8.	Someone older touching his/her private parts when they shouldn't.	☐ Yes ☐ No
9.	Someone forcing or pressuring sex, or when s/he couldn't say no.	☐ Yes ☐ No
10.	Someone close to the child dying suddenly or violently	☐ Yes ☐ No
11.	Attacked, stabbed, shot at or hurt badly	☐ Yes ☐ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed	☐ Yes ☐ No
13.	Stressful or scary medical procedure.	☐ Yes ☐ No
14.	Being around war	☐ Yes ☐ No
15.	Other stressful or scary event? Describe:	☐ Yes ☐ No

Which one is bothering the child the most now?_____

If you marked any stressful or scary events for the child, turn the page and answer the next questions.

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks. Answer the best you can:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always:

1.	Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2.	Having bad dreams related to a stressful event.	0	1	2	3
3.	Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4.	Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5.	Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6.	Trying not to remember, think about or have feelings about a stressful event.	0	1	2	3
7.	Avoiding anything that is a reminder of a stressful event (activities, people, places, things, talks).	0	1	2	3
8.	Not being able to remember an important part of a stressful event.	0	1	2	3
9.	Negative changes in how s/he thinks about self, others or the world after a stressful event.	0	1	2	3
10.	Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11.	Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12.	Losing interest in activities s/he enjoyed before a stressful event.	0	1	2	3
13.	Feeling distant or cut off from people around her/him.	0	1	2	3
14.	Not showing positive feelings (being happy, having loving feelings).	0	1	2	3
15.	Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	0	1	2	3
16.	Risky behavior or behavior that could harmful.	0	1	2	3
17.	Being overly alert or on guard.	0	1	2	3
18.	Being jumpy or easily startled.	0	1	2	3
19.	Problems with concentration.	0	1	2	3
20.	Trouble falling or staying asleep.	0	1	2	3

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others ☐Yes ☐No
2. Hobbies/Fun ☐Yes ☐No
3. School ☐Yes ☐No
4. Family relationships ☐Yes ☐No
5. General happiness ☐Yes ☐No