

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

	Never	Sometimes	Often
◆ Fidgety, unable to sit still	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
■ Feels sad, unhappy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
◆ Daydreams too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Refuses to share	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Does not understand other people's feelings	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
■ Feels hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
◆ Has trouble concentrating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Fights with other children	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
■ Is down on him or her self	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Blames others for his or her troubles	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
■ Seems to have less fun	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Does not listen to rules	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
◆ Acts as if driven by a motor	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Teases others	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
■ Worries a lot	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
● Takes things that do not belong to him or her	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
◆ Distracted easily	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>

For Office
Use Only:

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

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

Yes No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only:

Severity score: _____

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? Yes No
Describe:

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Family relationships | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Hobbies/Fun | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. General happiness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. School | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |