Intake Questionnaire For Children and Adolescents

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____ **Medicaid ID Number:** _____

Name: _____ **Date of Birth:** _____ **Gender: M F Non-binary (Circle all that apply)**

Address: _____ **City/State/Zip Code:** _____

Phone: _____ **Cell Phone:** _____

Email: _____ **Home Phone:** _____

◯ Foster ◯ Post-Adopt ◯ Non-Medicaid ◯ DWS ◯ WHS ◯ 295

◯ Self Pay ◯ Insurance ◯ MI-706 ◯ JJS

If you checked "Insurance" above, please fill out the insurance box(es) below:

Primary Insurance: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to you: _____

Policy Holder Address: _____ Policy Number: _____

Seconday Insurance: _____ Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to you: _____

Policy Holder Address: _____ Policy Number: _____

Parent or Guardian:

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Work Phone: _____

Email: _____ Occupation: _____

Emergency Contact ****This information is required by the state--please complete all sections****

MUST BE SOMEONE OTHER THAN PARENT/GUARDIAN LISTED ABOVE

Name: _____ Relation to Client: _____ Phone: _____

Email: _____ Address: _____

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

_____

_____

_____

How long has this been going on? _____

What made you come in at this time? _____

_____

_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____

_____

_____

Symptoms

Please **check** any sypmtoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Depressed Mood
- ☐ Rapid mood changes
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____

Weight gain: _____ lbs Weight loss: _____ lbs

- ☐ Difficulty catching your breath
- ☐ Increased muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memroy

☐ Flashbacks ☐ Nightmares
☐ Thoughts about harming or killing yourself ☐ Thoughts about harming or killing someone else

☐ Feeling as if you were outside yourself, detached, observing what you are doing
☐ Feeling puzzled as to what is real and unreal
☐ Persisten, repetitive, intrusive thoughts, impulses, or images
☐ Unusual visual experiences such as flashes of light, shadows
☐ Hear voices when no one is present
☐ Feeling that your thouths are controlled or placed in your mind
☐ Feeling that the television or the radio is communicatiing with you

☐ Difficulty problem solving ☐ Difficulty meeting role expectations
☐ Dependency on others ☐ Manipulation of others to fulfill your own desires
☐ Inappropriate expression of anger ☐ Self-mutiliation/cutting
☐ Difficulty or inability to say "no" to others ☐ Ineffective communication
☐ Sense of lack of control ☐ Decreased ability to handle stress
☐ Abusive relationship ☐ Difficulty expressing emotions
☐ Concerns about your sexuality

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other
☐ I prefer not to say

Please describe any other symptoms or experiences you have had problems with:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?
☐ No ☐ Yes If so:

Name of Therapist: _____ Dates of Treatment

Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been	Has it been helpful?

Are you **CURRENTLY** taking NON-**PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been	Has it been helpful?

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	Dosage	How long have you been	Has it been helpful?

Have you been hospitalized for psychiatric reasons? ☐No ☐Yes If YES, please list:

Hospital	Dates	Reason

Have you ever attempted suicide? ☐No ☐Yes If YES, please list:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition(s)? ☐No ☐Yes If YES, please list:

List any PRIOR illnesses, operations, and accidents:

FAMILY HISTORY

Father: Age: _____ ☐Living ☐Deceased Cause of death: _____
If deceased, HIS age at time of his death: _____ YOUR at time of his death: _____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: _____ ☐Living ☐Deceased Cause of death: _____
If deceased, HER age at time of her death: _____ YOUR at time of her death: _____
Occupation: _____ Health: _____
Frequency of contact with her: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**

During your childhood, have you lived any significant period of time with anyone other than your natural parents?
☐No ☐Yes If so, please give the person's name and relationship to you:

Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives.

	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems						
Depression						
Hyperactivity						
Counseling						
Psychiatric Hospitalization						
Suicide Attempt						
Death by Suicide						
Drinking Problem						

SOCIAL HISTORY

Education

Highest grade level completed so far: _____

Have you had any disciplinary problems in school? _____

If yes, please explain: _____

Were you considered hyperactive/ADHD in school? _____

If yes, were/are you on any medication? _____ If so, which medication? _____

What kind of grades do you get in school? _____

General

Have you been arrested or had any contact with the plice? _____

If yes, please describe: _____

Do you have a religious affiliation? _____ If so, what is it? _____

What kind of social activities do you participate in? _____

_____

Who do you turn to for help with your problems? _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglested

Please describe: _____

_____

_____

_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? _____ If yes, age of first use: _____

How much do you drink? _____

How often do you drink? _____

Do you use tobacco (cigarettes, dip)? _____

If yes, how often? _____

Do you vaoe? _____ If yes, how often? _____

Other drugs:

Please indicate for each drug listed below.

Drug	**Ever used**	**Age at 1st use**	**Time since last use**	**Approx use in last 30 days**
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?