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 of the child's siblings

Name	Age	Gender	Relationship to the Child (Biological, Step, Half, etc)	Currently Living in your Home?	Does this child have any behavioral or emotional challenges? (Describe)
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

DEVELOPMENTAL HISTORY

Please list any difficulties that occurred during pregnancy or delivery:

Please describe any concerns related to your child's development:

Briefly describe any aspects of your family or family history that you believe may have a bearing on present difficulties:

HEALTH

Please list all major illnesses, injuries, surgeries, accidents, or other medical conditions that your child has experienced:

Dates	Incident	Treating Physician

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

Dates	Reason	Therapist/Psychologist

Please list all psychological or psychiatric hospitalizations that your childrecieved:

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 SEAKING 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 (eg. 3rd 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 you 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 life 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 plying 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_____ Extreme Problem_____
Definitely does not need treatment or special services. 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_____ Extreme Problem_____
Definitely does not need treatment or special services. Definitely needs treatment or special services.

2.. How your child's challenges affect their relationship with you?

No Problem_____ Extreme Problem_____
Definitely does not need treatment or special services. Definitely needs treatment or special services.

3. How your child's challenges affect their academic progress at school

No Problem_____ Extreme Problem_____
Definitely does not need treatment or special services. Definitely needs treatment or special services.

4. How your child's challenges affect their self-esteem.

No Problem_____ Extreme Problem_____
Definitely does not need treatment or special services. Definitely needs treatment or special services.

5. How your child's challenges affect your family in general

No Problem_____ Extreme Problem_____
Definitely does not need treatment or special services. Definitely needs treatment or special services.

6. Overall severity of your child's challenges in functioning and overall need for treatment

No Problem_____ Extreme Problem_____
Definitely does not need treatment or special services. Definitely needs treatment or special services.

CLINICAL QUESTIONAIRE

(Patients 14 years old and up)

This questionnaire is designed to supply your therapist with comprehensive information about your past history and present situation. By completing these questions as fully and accurately as you can, you will facilitate your clinical assessment and therapy program. Thank you.

1. General Information:

Date: _____

Name: _____ Spouse Name:_____

Address: _____ Sex: □ Male □ Female

_____ Age:_____ Date of Birth: _

Phone number_____ □ Home □ Cell □ Work Date of Birth:_____
Phone number_____ □ Home □ Cell □ Work

Marital Status (please check one of the following):
□ Single □ Engaged □ Married □ Divorced □ Remarried □ Living together □ Widowed

Do you have any children? Yes____ No_____

If so, please list names and ages below:

NAME:	AGE:	/	NAME:	AGE:
_____	_____	/	_____	_____
_____	_____	/	_____	_____
_____	_____	/	_____	_____
_____	_____	/	_____	_____

Primary Care Physician (PCP): _____

Address: _____

Health Insurance: _____

2. Current Clinical Data:

(a.) Describe the main problem(s) that led you to seek therapy at this time, including the duration of this problem (or set of problems):

(b.) Briefly describe the history of this problem, or set of problems, including a list of stress factors which seem to be triggering and/or intensifying the problem now:

(c.) Circle the degree to which you have been experiencing each of the following Moods, Emotions and Feelings as a result of the problem(s) that led you to seek therapy:

	Not at all	To only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Angry	0	1	2	3
2. Panicky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10. Lonely	0	1	2	3
11. Resentful	0	1	2	3
12. Dependent	0	1	2	3
13. Confused	0	1	2	3
14. Guilty	0	1	2	3
15. Nervous	0	1	2	3
16. Listless	0	1	2	3
17. Hopeless	0	1	2	3
18. Tense	0	1	2	3
19. Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21. Terrified	0	1	2	3
22. Embarrassed	0	1	2	3
23. Elated	0	1	2	3
24. Abandoned	0	1	2	3
25. Agitated	0	1	2	3
26. Worried	0	1	2	3
27. Helpless	0	1	2	3
28. Grief	0	1	2	3

Other emotional reactions:

_____

_____

_____

Circle how often you have been bothered by each of the following Difficulties with Thinking since the problem(s) that led you to seek therapy began:

	Never	Occasionally	Often
1. Concentration difficulties	0	1	2
2. Difficulty remembering things	0	1	2
3. Your mind going "blank"	0	1	2
4. Difficulty making decisions	0	1	2
5. Difficulty making sound judgments	0	1	2
6. Distractible	0	1	2
7. Thoughts are "racing"	0	1	2
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2
9. Repetitive thought(s), image(s), or urge(s)	0	1	2
10. Suicidal thoughts	0	1	2
11. Thoughts of killing someone	0	1	2
12. Preoccupation with death	0	1	2

Other problems not listed above:

_____

_____

_____

Circle how much you have been distressed or bothered by each of the following Physical Reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All or Only a Minimal Degree	To a Moderate Degree	To a Very Strong Degree
1. Shortness of breath or smothering sensations	0	1	2
2. Nausea, diarrhea, or other abdominal stresses	0	1	2
3. Trouble swallowing or "lump in throat"	0	1	2
4. Muscle tension, aches, or soreness	0	1	2
5. Flushes (not flashes) or chills	0	1	2
6. Dizziness or light-headed	0	1	2
7. Trouble falling or staying asleep	0	1	2
8. Sweating or cold clammy hands	0	1	2
9. Fatigue or loss of energy	0	1	2
10. Decrease in appetite	0	1	2
11. Weight loss	0	1	2
12. Decreased need for sleep	0	1	2
13. Numbness or tingling sensations	0	1	2
14. Weepiness/crying	0	1	2
15. Palpitations or accelerated heart rate	0	1	2
16. Headaches	0	1	2
17. Increase in appetite	0	1	2
18. Weight gain	0	1	2
19. Increased need for sleep	0	1	2
20. Chest pains or discomfort	0	1	2
21. Physical problems (for example, impaired physical functioning, physical pain, etc.)	0	1	2
22. Awakening earlier in the morning than you normally do.	0	1	2

Other physical reactions:_____

_____

_____

Circle the degree to which you have been experiencing each of the following additional reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feelings like you want to beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)	0	1	2	3
14. Increased alcohol use	0	1	2	3
15. Use of "street" (non-prescription) drugs	0	1	2	3

Any other effects or reactions; stemming from your problem(s), not described above:

_____

_____

(d.) Family Functioning: Briefly describe how *the problems you are having,* have been affecting your relationship with family members (i.e. spouse, partner, children and other significant relatives):

(e.) Social Functioning: Briefly describe how *the problems you are having,* have been affecting your social functioning with non-family members (i.e. relationship with friends):

(f.) Work/ School Functioning: Briefly describe any ways that you feel your functioning at work and, if relevant, at school, has been affected by *your current problem(*s) (i.e. performance levels, relationship with co-workers)

(g.) Please place a checkmark in the appropriate box for each of the following

Have you ever:	**Present**	**Past**	**Future**
1. Purposely injured yourself without suicidal intent (e.g. cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g. friend, family, partner, or authority figure) with cruel or malicious intent			
9. Been involved in child abuse a.) as a victim/survivor b.) as a perpetrator			
10. Been involved in sexual abuse a.) as a victim/survivor b.) as a perpetrator			
11. Had an eating disorder			
12. Felt that something was wrong with your mind			
13. Physically threatened another person			
14. Assaulted or attempted to kill another person			
15. Felt your thoughts were so loud people could hear them			
16. Had periods of time you can't account for			
17. Had periods of severe depression			
18. Believed others were conspiring against you			
19. Had periods in which you felt extremely optimistic, full of energy, could get by on little or no sleep, and/or thought and talked very fast			
20. Felt compelled to help other people			
21. Felt compelled to isolate yourself			

(h.) Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours	Used in Last 6 Months
Alcohol					Y N	Y N
Nicotine					Y N	Y N
Marijuana					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N

If you have used alcohol:

1. Have you ever tried to cut down on your drinking? † Yes † No
2. Have you ever been annoyed at other's complaints about your drinking? † Yes † No
3. Have you ever felt guilty about your drinking? † Yes † No
4. Have you ever taken a morning "eye opener" (drink)? † Yes † No

Are there particular situations in which drug or alcohol use tends to occur? † Yes † No

If Yes, please describe:

Is your <u>current</u> use of alcohol and/or drugs causing or contributing to problems in any aspect of your functioning (relationship with others, functioning at work or school, etc,)?

† Yes † No

If yes, describe the nature of the problem(s) stemming from your current use of alcohol and/or drugs:

3. <u>Historical Clinical Data</u>

a.) Have you had any <u>previous</u> issues for which you feel a mental health professional should have been seen, or for which you actually did seek professional help? † Yes † No

If yes, state the issue(s):

Did you receive professional help for these issues: † Yes † No

If you were seen as an *outpatient*, indicate <u>when</u> and <u>where</u> you were seen and the <u>name(s) of the professional(s)</u> with whom you were in treatment:

If you were seen as an *inpatient*, indicate where you were hospitalized, and the name(s) of the professional(s) with whom you were in treatment:

(b.) If you have received professional help for alcohol or substance abuse problems, indicate when and where you received treatment, and the name of your primary counselor or therapist:

(c.) Is there any family history of alcohol or drug problems, and/or problems of a psychiatric nature? † Yes † No

If yes, describe the nature of these problems:

5. Family Data

(a.) Father:
If alive, his present age:_____
If deceased, your age and his age at his time of death:(your age/his age)_____
Cause of death: _____
Occupation: _____
How would you describe your father, and how did you get along with him?

(b.) Mother
If alive, her present age:_____
If deceased, your age and her age at her time of death:(your age/her age)_____
Cause of death: _____
Occupation: _____
How would you describe your mother, and how did you get along with her?

Brothers and Sisters:

Name	Age	How did/do you get along with him/her
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(c.) Were you adopted as a child? † Yes † No

(d.) Were you diagnosed as a hyperactive child? † Yes † No

(e.) Were your parents separated or divorced as a child? † Yes † No

(f.) Were either of your parents seriously physically ill and/or absent for long periods of time during your growing up years? † Yes † No

(g.) Briefly describe any experiences that you had while growing up that you believe may have a bearing on your present problem(s):

(h.) Spouse/Partner Name:_____ Age_____

Occupation_____ Years married_____

How would you describe your spouse or partner, and how do you get along with him or her?

If divorced/divorcing, reason for divorce?

(i.) Repeat the above for 2nd spouse:

6. Social/Educational/Employment/Legal Data

(a.) Briefly describe any aspects of your social history, other than in your family of origin, which you believe may have a bearing on your present problem(s):

(b.) Indicate the highest level of formal education that you have obtained:

(c.) Briefly describe any experiences relating to school that you think may have a bearing on your present problem(s):

(d.) Indicate your current occupation:_____

(e.) How many times have you changed jobs in the last 5 years?_____

(f.) Are you a combat veteran? † Yes † No
If yes, which War(s):

(g.) Have you had any problems of a legal nature (including arrests)? † Yes † No
If yes, briefly describe what this involved:

7. Medical Data

(a.) If you have had any past or current medical illnesses, surgeries, or traumas, give a brief description of these, including when they occurred:

Dates	Incident	Treating Physician

(b.) List any current medications, including dosage, that you take:

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

(c.) Indicate any allergies that you have:

(d.) The date of your last physical: _____