Amy Burley, M.A, LPC
2309 Coit Road, Suite C Plano, TX 75075/ 214-494-1990

CHILD INTAKE QUESTIONNAIRE

Please answer as completely as possible and return to Therapist.

Today's Date: _____ Child's Name: _____

Child's Date of Birth: _____ Age: _____ Gender: M_____ F_____
Child's Cell Phone (if applicable): _____
Home Address: _____
School: _____ School District: _____
Grade Level (now):_____ School Counselor: _____
School Counselor Phone & Email: _____: _____
Has the child received 504, SpEd, behavioral, or other services? No_____ Yes _____ If yes, please describe: _____
Has this child received prior counseling? No____ Yes ____ If yes, where & with whom?
_____Phone Number: _____

Has the Child witnessed or experienced any of the following:
_____ Verbal abuse
_____ Physical abuse
_____ Sexual abuse or molestation
_____ Bullying
_____ Emotional neglect or physical abandonment
_____ Parental divorce, remarriage, etc.
_____ Health issues requiring frequent, intensive, or prolonged medical care/ hospitalization or surgery
_____ Dietary restrictions
_____ Body shaming or weight shaming
_____ Domestic violence or intense arguments between parents or step-parents

PARENT INFORMATION:

Mother's Name: _____ Cell Phone: _____
EMAIL: _____ Marital Status: (married, single, separated, divorced, cohabitating) _____ # of Marriages: _____
Any History of learning, emotional, behavioral problems: _____Yes _____ No (if yes, please explain)
_____
Any History of alcohol/drug/substance abuse: Yes _____ No_____ (if yes, explain)
_____
History of family violence: Yes_____ No_____ (if yes, explain) _____
_____

Father's Name: _____ Cell Phone: _____
Email: _____ Marital Status: (married, single, separated, divorced, cohabitating) _____ # of Marriages: _____

Any history of learning, emotional, or behavioral problems? Yes _____ No _____ (if yes, explain)

_____

_____

History of alcohol/drug/substance abuse? Yes _____ No_____ (if yes, explain)

_____

Child's Family of Origin- Please list each family member, including the Child.

Name	Age	Gender	Relationship to Child
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

CHILD'S HEALTH:

Child's Physician: _____ Phone number: _____

List any present medical problems or current medications: _____

_____

Has the child had any psychiatric care? _____ Yes _____ No If yes, please indicate when and with whom: _____ Phone: _____

Does the Child have a prior mental health or neurological diagnosis? If yes, please explain:

_____

CHILD'S HISTORY AND EXPERIENCES- Please mark an X next to any symptoms that Child has experienced in the last 6 months.

_____ Suicidal thoughts	____ Suicide Attempts	_____ Self-harm
_____ Appetite change	____ Weight loss	_____ Weight gain
_____ Mood swings	____ Hears voices when no one around	____ Loss of energy or fatigue
_____ Anger, outbursts	____ Feeling down, Depressed	____ Trouble sleeping
_____ Crying spells	____ Social isolation	____ Poor grooming
____ Insomnia	____ Sleeping too much	____ Lack of motivation
____ Lack of enjoyment	____ Feeling "on top of the world"	____ Feelings of hopelessness
____ Difficulty concentrating	____ Decreased interest in hobbies	___ Risky behavior
____ Loneliness	____ Aggressive behavior	___ Keyed up, on edge
____ Obsessive worrying	____ Irritable	____ Phobias, specific fear(s)
____ Anxiety symptoms	____ Feelings of panic	____ Irrational thoughts

____ Racing thoughts	____ Unable to control thoughts	____ Unable to relax
____ Nervous habits (nail biting, etc.)	____ Feels inferior	____ Nervous stomach
____ Nightmares	____ Bedwetting	____ Constipation
____ Holding urine/ feces; soils clothes	____ Frequent pains	____ Dizziness
___ Chest pains	____ Memory problems	____
___ Binging/ purging food	____ Anorexia, restricts eating	____ Lack of Self-control
___ Trouble w/ focus or concentration	____ Trouble starting or completing tasks	____ Impulsive, poor impulse control
___ Unable to sit still	____ difficulties with school work	____ low self-confidence
___ hard time keeping friends or relating to peers	____ seems driven by a motor	____ poor choices in friends
___ trust issues w/ parents	____ manipulated by peers	____ Bullying or social exclusion
___ illness of a loved one	____ death of a loved one	____ argumentative
___ immature for age	____ angry, explosive	____ destructive or sets fires
___ cruel to pets or animals	____ doesn't sleept in own bed	____ picked on at school
___ worries about germs, illness	____ likes to be in control	____ has run away
___ has engaged in self-harm	____ brave, extroverted	____ likes to try new things
___ cautious, timid in new situations	____ prefers same routine	____ has meltdowns at end of day
___ seems to lack empathy for others	____ seems to live in own world	____ becomes interested in one topic for a while then goes to next one for a while, going in depth on each

What kinds of physical activity/ exercise does your child have on a weekly basis?

_____

_____

What does the Child typically eat in a day/ week? _____

_____

SOCIAL SUPPORTS and HOME ENVIRONMENT

What do you see as this child's strengths? _____

_____

_____

(Place a Check in front of the number that best applies to the statements below)

Family Support System (such as friends, relatives, school or religious organization)

Hardly any support ____1____2____3____4____5 Considerable support

How Strict are the Household Rules.

Very relaxed ____ 1____2____3____4____5 Very Strict

How Consistent is the Follow Through on Consequences.

Not Consistent at all ____ 1____2____3____4____5 Very Consistent

How much television does your child watch each week?

____ 2-5 hrs ____ 5-8hrs ____ 8-12hrs _____ 12-16hr _____16+hrs

How many hours does your child spend playing non-educational video games each week?

____ 2-5 hrs ____ 5-8hrs ____ 8-12hrs _____ 12-16hr _____16+hrs

Please note how discipline occurs in the Child's home:

_____ Offering alternate choices _____ Giving time outs _____ Loss of privilege

_____ Using timers _____ Using task lists _____ Noticing desired actions

_____ Having a cool down space _____ Lecturing child _____ Yelling

_____ Spanking _____ Asking Child what he/she could do differently next time

_____ Hitting _____ Threats, name calling _____ Comparisons to others

Is there anything else that you would like for the Therapist to know that would help in providing counseling to the Child?

_____

_____

_____

_____