Child Development/History Intake Questionnaire
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Today's Date:
Child's Name:
Name of Person Completing Questionnaire:

REFERRAL INFORMATION:

1. What are you concerned about that you are seeking help for your child?

2. Who referred you to this clinic?

FAMILY HISTORY:

1. With whom does this child live?

2. Is this child closer to one parent than the other? Yes No
   If so, which parent?

3. Has this child experienced any parental separations, divorce, or death? Yes No
   If so, please describe the circumstances.

4. Who has legal custody of this child?

5. How often does the noncustodial parent visit the child (if applicable)?

6. Has either parent experienced any mental health problems (e.g., depression, anxiety, schizophrenia, etc.?

7. Does either parent have a history of chemical abuse problems?

8. Does either parent have a history of legal problems?

9. Does either parent have a history of significant medical problems?

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BROTHERS/SISTERS:

Please list all brothers and sisters, and any other children living with the family:

First name: Age: Sex: Relationship to this child: Living at home?

How well does this child get along with brother(s) or sister(s)?

FAMILY RELATIONSHIPS:

Check the activities that this child often participates in with the family:

____Movies ____Meals ____Conversations ____Church ____Games

____Sports ____Television ____Trips ____Visiting Relatives ____Other

1. What do you enjoy most about this child?
2. What do you find most difficult about raising this child?
3. Who is in charge of discipline in the home?
4. Describe discipline techniques used with this child.
5. Has child protection services ever been involved with this child? If so, please describe the circumstances.
6. Has this child ever been the victim of physical of sexual abuse? If so, please describe the circumstances.

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PREGNANCY:

1. Was this child a planned pregnancy?

2. Was the mother under a doctor's care?

3. Were there any medical complications with this child DURING the pregnancy? If so, describe.

4. Were alcohol, drugs, cigarettes, or other chemicals used during the pregnancy with this child?

5. Were there any medical complications upon the BIRTH of this child? If so, describe.

DEVELOPMENT:

1. At what age did this child first do the following? Please indicate year/month.

_____ Crawl _____Walk alone _____Speak first words _____Fully toileted

2. Did this child have problems with bedwetting or soiling after toilet training? If so, describe.

3. During this child's first 4 years, were any problems noted in the following areas? If so, describe.

____ Eating ____Sleeping ____Speech problems ____Excessive crying

____Coordination ____Failure to thrive ____Separating from parents

____Temper tantrums

4. Which hand does this child use for writing or drawing?

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MEDICAL HISTORY:

1. Has this child experienced any serious medical problems?
2. Has this child ever been hospitalized for any medical condition?
3. Has this child ever experienced any injuries to his/her head?
4. Does this child receive medication currently for any medical condition?
5. Does this child have allergies?
6. Has this child experienced lead exposure?
7. Does this child wear glasses or contact lenses (or need them but not currently have them)?
8. Does this child have any problems hearing?
9. What medical clinic does this child go to for medical care?

   Physician:
10. Has this child ever been to a psychologist, psychiatrist, or counselor before? If so, give dates and details of this experience.

FRIENDSHIPS:

1. Please indicate how this child relates to other children. If yes, describe.

   Fights frequently with other children? Yes No

   Prefers playing with younger children? Yes No

   Has difficulty making friends? Yes No

   Prefers to play alone? Yes No

RECREATION / INTERESTS:

1. What activities does this child enjoy?

   Sports:

   Hobbies:

   Other:

2. Has this child's interest in participating in these activities declined recently? If so, describe.

BEHAVIOR / TEMPERAMENT:

1. Please indicate whether this child exhibits any of the following behavior:

Has a short attention span	No	Yes
Lacks self-control	No	Yes
Seems unhappy most of the time	No	Yes
Hides feelings	No	Yes
Trouble stopping before doing things	No	Yes
Hyperactive	No	Yes
Shy	No	Yes
Requires a lot of parental attention	No	Yes
Seems angry most of the time	No	Yes
Seems nervous or anxious	No	Yes

EDUCATION:

Child's current school:

Child's current grade:

1. Please indicate whether this child has had any of the following school experiences:

Has changed schools		No	Yes
Has been held back a grad	No	Yes	
Has difficulty with reading	No	Yes	
Has difficulty with math		No	Yes
Gets poor grades	No	Yes	
Has been tested for special education	No	Yes	
Currently is placed in special education (if yes, what type of classroom?)	No	Yes	
Dislikes going to school		No	Yes
Has received suspension from school	No	Yes	

2. Do you have any concerns about the quality of your child's school or teachers? If yes, describe.

GOALS:

1. What would you like to see different with this child by seeking mental health services at this time?

2. What are three goals that you would like to work on with your child in his/her treatment?

ADDITIONAL COMMENTS: