**CHILD INTAKE QUESTIONNAIRE**

**Information About Child Being Evaluated:**

Name:

Date of Birth:

Who should we contact in case of an emergency (please list at least 2 contacts)?

Please list the name, address, phone number, and fax number for your child’s primary medical doctor/provider.

Health card Number and Province:

Please provide the name of your pharmacy, address, phone number and fax number for your prescriptions to be sent to.

Do you or your family have any strong cultural or religious beliefs? If so, please describe.

**Information About You:**

Name:

Phone number:

Address:

Relationship to child (biological parent, foster parent, etc.):

**Present Concerns:**

What are your main concerns for your child to be seen at the practice:

How long have these issues been going on for:

Please place an X next to each problem your child experiences **presently**:

Depressed mood:

Loss of interest or enjoyment in activities previously enjoyed:

Poor sleep:

Feelings of guilt:

Feelings of worthlessness:

Feelings of hopelessness:

Poor energy:

Poor concentration due to low mood:

Poor appetite:

Feeling sluggish or weighed down:

Being easily distracted:

Being very irritable:

Feeling like you are on top of the world or like you have super powers:

Racing thoughts:

Excessive activity:

Little need for sleep for days in a row:

Panic attacks:

Fear of using public transportation:

Fear of being in open spaces:

Fear of being in enclosed spaces:

Fear of being outside of the home alone:

Excessive and intense worrying about potential judgement or criticism in social settings:

Avoiding meeting new people or being involved in social interactions:

Excessive worrying about everyday life events and tasks:

Feeling restless, keyed up, or on edge:

Poor concentration due to being distracted with worries:

Muscle tension when worried:

Repeatedly checking things:

Excessive hand washing or cleaning:

Compulsive need for neatness/order:

Rituals or routines your child feels must be performed:

Needing to do things a certain number of times or constantly counting things:

Need for symmetry:

Restricting what they eat to lose weight or avoid gaining weight:

Binge eating episodes:

Forcing themsleves to throw up after eating excessively:

Taking laxatives after eating excessively:

Exercising excessively because of poor body image:

Difficulties relating to others in social situations:

Problems making and/or maintaining friendships:

Difficulty in interpreting non-verbal cues in social situations:

Problems with purposeless repetitive movements or repeating words/phrases:

Problems with changes in routines and habits:

Tendency to have intense fixated interests or hobbies:

Sensory issues (sound, light, textures, pain, temperature):

Failing to give close attention to details or making careless mistakes often or very often:

Difficulty sustaining attention often or very often:

Not listening when others are speaking directly to them often or very often:

Struggling to follow through on instructions often or very often:

Difficulty with organization often or very often:

Avoiding or disliking requiring a lot of thinking often or very often:

Losing things often or very often:

Being easily distracted often or very often:

Being forgetful in daily activities often or very often:

Fidgeting with hands or feet or squirming in chair often or very often:

Difficulty remaining seated often or very often:

Running around or climbing excessively in children often or very often; extreme restlessness in adults:

Difficulty engaging in activities quietly often or very often:

Acting as if driven by a motor often or very often; adults will often feel inside like they were driven by a motor:

Talking excessively often or very often:

Blurting out answers before questions have been completed often or very often:

Difficulty waiting or taking turns often or very often:

Interrupts or intrudes upon others often or very often:

Hallucinations:

Feeling like people are watching them or are after them:

Grief/loss:

Chronic pain issues:

Difficulty with work, school, or family:

**Child’s Mental Health History:**

Has your child been given any mental health diagnoses in the past:

 If yes, please list:

Has your child ever been in mental health treatment (not including psychiatric hospitalizations):

If yes, where (list all) and what kind of treatment:

When were they in treatment:

Was the treatment helpful? Why or why not:

Has your child ever taken medication to help with behavior, mood, or other mental health problems:

If yes, what medication(s):

What medication was helpful:

Did your child have any side effects from the medication:

Has your child ever been admitted to the psychiatric hospital?

If yes, where?

When were you admitted to the psychiatric hospital?

Has your child ever been seen in a psychiatric emergency room but not admitted to the hospital:

If yes, where and when:

Has your child ever had any suicidal thoughts, suicide attempts or self-injurious behaviors (cutting, self-mutilation, etc):

 If yes, please describe:

Has your child ever had any thoughts of hurting others:

 If yes, please describe:

Do your child have any history of violence or aggression:

If yes, please describe:

**Child’s School History:**

Where your child goes to school:

Current grade level:

What are your child’s grades like (A’s, B’s, C’s, D’s, failing):

Have your child’s grades always been like this:

If no, please explain:

Has your child ever had an Individualized Education Plan (IEP):

If yes, what grade(s) did your child have this plan:

What services or help did your child receive with the IEP:

Has your child ever been suspended from school:

If yes, how many times and in what grade(s):

Why was your child suspended:

Has your child ever repeated a grade:

 If yes, please explain reasons:

**History of Trauma or Abuse:**

Has your child ever experienced any trauma or abuse (emotional, physical, or sexual):

If yes, please describe the traumatic event or abuse:

**Child’s Family History:**

Please list any **mental illnesses** (depression, anxiety, bipolar disorder, schizophrenia, autism, intellectual disability, ADHD, etc) experienced by the following family members:

Mother:

Father:

Siblings:

Mother’s parents:

Father’s parents:

Any other family members:

Please list any family members that **have alcohol or drug problems** and explain:

Mother:

Father:

Siblings:

Mother’s parents:

Father’s parents:

Any other family members:

Has anyone in your child’s family (mother’s and father’s side) attempted or committed suicide:

If yes, who:

Does anyone in your child’s family (mother’s and father’s side) have a history of legal problems or incarcerations:

If yes, who:

Do any of the following family members suffer from medical problems (asthma, diabetes, high cholesterol, high blood pressure, thyroid problems, cancer, heart disease or heart attack, stroke, etc): If “Yes,” please explain. Also, if the medical condition is a heart problem, please indicate the age that the condition began.

Mother:

Father:

Siblings:

Mother’s parents:

Father’s parents:

Any other family members:

**Living situation:**

Who does your child live with:

**Employment, Military and Legal History:**

Where was your child born and raised:

Who is/are part of your child’s support system:

Does your child currently work:

 If so, please describe what your child does for work:

 How long has your child worked in this position:

Has your child ever had any history with the legal system:

**Hobbies, interests, spirituality:**

Please tell us about any important hobbies, interests or spiritual beliefs or practices for your child that you would like us to know about:

**Child’s Substance Abuse History:**

Does your child smoke cigarettes or vape nicotine:

 If yes, how much does your child use each day:

 When did your child start smoking or vaping:

Does your child regularly drink caffeine:

 If yes, how much does your child drink each day:

Does it cause any problems, like feeling anxious or jittery or having a hard time sleeping:

Does your child currently drink alcohol:

 If yes, how often:

 How much does your child drink when you do:

 Does the alcohol use cause any problems:

 Has your child had problems with alcohol in the past, if not now:

Does your child currently use any drugs (including marijuana):

 If yes, what drugs:

How often:

 How much does your child use when they do:

 Does the drug use cause any problems:

 Has your child had problems with drugs in the past, if not now:

Has your child ever participated in substance abuse treatment, such as detox, rehab, or outpatient treatment:

 If yes, please describe:

**Developmental history:**

What was your child’s birth weight:

What was your child’s gestational age at birth:

Was your child born by C-section or vaginal delivery:

Any complications during the pregnancy with your child:

 If yes, please give details:

Any complications during your child’s birth or after your child’s birth:

 If yes, please give details:

Did your child require stay in the NICU:

If yes, please give details:

Was your child ever exposed to any alcohol, tobacco, illicit drugs or prescription drugs in-utero:

 If yes, please give details:

Did your child reach your developmental milestones on time:

**Current Medications:**

Please list all **medications** (for medical and psychiatric reasons, including prescription and over-the-counter medication, and doses and when your child takes the medication, such as each morning or on Sundays) that your child takes at this time and **why** your child takes the medication:

If your child takes medication, do you or your child find it helpful: For either answer, please explain:

**Medical History:**

Does your child have any medical problems:

If yes, please list all medical problems:

Has your child ever had one of the following: If “Yes,” please explain.

 Surgery:

 Medical hospitalization:

 Head injury:

 Seizures:

 Heart problems:

Does your child have any allergies:

If yes, please list the medication and what the reaction is:

Other than your primary medical doctor that you listed above, does your child see any other medical doctors/providers:

If yes, who (please include the name, contact information, and reason you meet with this person):

When was your child’s last physical exam:

When was your child’s last bloodwork:

 Was anything abnormal:

If you know, please list what these were when last checked for your child:

 Blood pressure:

 Heart rate:

 Height:

 Weight:

If your child is female:

When was your child’s last menses, if this has started:

Is your child or could your child be pregnant:

**Further information that you feel is important but not previously asked in this questionnaire):**