Innervisions Counseling & Consulting Center S.C.

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INTAKE QUESTIONNAIRE – CHILD

*Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.*

|  |  |
| --- | --- |
| Date: |       |
| Name of Person Completing Form: |       |
| Child is: | [ ]  My Biological Child[ ]  My Adopted Child[ ]  My Foster Child[ ]  Other:       |

| IDENTIFYING INFORMATION *(for individual receiving services)* |
| --- |
| Child’s Name: |       |  | Date of Birth: |       |
| Street Address: |       |  | Sex: |       |
| City/State/Zip: |       |  | Cell Phone: |       |
| Home Phone: |       |  | Who’s Cell Phone: |       |
| SSN: |       |  | Household Income: |       |
|  |  |  | Preferred Pronouns: | [ ] He/His/Him[ ] She/Hers/Her |
| Who referred you to Innervisions? |       |
|  |  |

| CHILD’S RACE: |
| --- |
| [ ]  White/Caucasian[ ]  American Indian or Alaska Native[ ]  Native Hawaiian or Pacific Islander[ ]  Unknown | [ ]  Asian[ ]  Black/African American[ ]  Two or more races |

| CHILD’S ETHNICITY: |
| --- |
| [ ]  Hispanic or Latino[ ]  Non-Hispanic or Non-Latino |  |

| CHILD’S LANGUAGE OF CHOICE: |
| --- |
| [ ]  English[ ]  Hmong[ ]  Russian[ ]  Laotian | [ ]  Spanish[ ]  German[ ]  French[ ]  Other:       |

| FAMILY’S RELIGIOUS AFFILIATION: |
| --- |
| [ ]  Catholic[ ]  Muslim[ ]  Jewish[ ]  Amish[ ]  Mennonite | [ ]  Protestant *(including Lutheran, Methodist, etc.)*[ ]  Non-Denominational[ ]  No Affiliation[ ]  Other:       |

| DISABILITY: |
| --- |
| Do you have a disability? [ ]  No [ ]  Yes* If yes, please specify:
 |
| If you have a disability, does the office accommodate your needs? [ ]  No [ ]  Yes |
| * If no, please explain:
 |
| If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below: |
| *
 |

| PRESENTING PROBLEM *(current situation and history)*: |
| --- |
| What is the primary problem for which you are seeking help? |
| [ ]  Behavior at home[ ]  Family problems[ ]  Depression[ ]  Mood Swings[ ]  Behavior at school[ ]  Self-confidence | [ ]  Overactivity[ ]  Peer problems[ ]  Eating disorder[ ]  Alcohol/drug use[ ]  Physical problems[ ]  School Performance | [ ]  Grieving[ ]  Abuse or trauma[ ]  Relationship[ ]  Anger[ ]  Anxiety or worry[ ]  Other *(explain below)*: |
| *
 |
| How long has the child had this/these problems *(indicate below)*? |
| *
 |
| Has the child received treatment for this problem or any other problem in the past? | [ ]  No [ ]  Yes |
| * If yes, when, where and with whom?
 |

| SUICIDE RISK: |
| --- |
| Suicide Risk: | [ ]  Denies | [ ]  Ideation | [ ]  Intent | [ ]  Plan | [ ]  Attempt |
| Notes: |       |
| Danger to Others: | [ ]  Denies | [ ]  Ideation | [ ]  Intent | [ ]  Plan | [ ]  Attempt |
| Notes: |       |
| Past History of Suicide Risk: |       |
| Current/Recent Suicide Risk: |       |

| FAMILY HISTORY: |
| --- |
| With whom does the child currently live? | Name(es):  |       |
|  | Relationship: |       |
| Has the child lived with anyone else in the past? | [ ]  Yes[ ]  No[ ]  With whom?       |
| Does the child or any other family member have a history of alcohol or drug problems? | [ ] Yes[ ] No |
| * *If yes, please explain:*
 |
| Has the child or any other family member experienced any type of abuse *(physical, sexual, domestic or emotional)*? | [ ] Yes[ ] No |
| * *If yes, please describe the circumstances:*
 |
| Please provide the following information about the child *(as applicable)*: |
| Father: | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |
| Mother | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |
| Stepfather | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |
| Stepmother | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |
| Foster Father | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |
| Foster Mother | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |
| Guardian/Other | Name: |       |
|  | Phone #: |       | DOB: |       |
|  | Full Address: |       |
|  | Occupation: |       |
|  | Education: |       |

| Please provide the following information about the child’s brothers/sisters and other children living in the home: |
| --- |
| First & Last Name | DOB | Relationship*(full, half, step, foster)* | Lives with Child? | If no, lives where? |
|       |       |       | [ ] Yes [ ] No |       |
|       |       |       | [ ] Yes [ ] No |       |
|       |       |       | [ ] Yes [ ] No |       |
|       |       |       | [ ] Yes [ ] No |       |
|       |       |       | [ ] Yes [ ] No |       |
|       |       |       | [ ] Yes [ ] No |       |
|       |       |       | [ ] Yes [ ] No |       |

| LEGAL HISTORY: |
| --- |
| Please describe any involvement the child has had with the legal system *(arrests, convictions, probation and parole)*:       |

|  |
| --- |
| DEVELOPMENTAL HISTORY: |
| Pregnancy and delivery were normal?* If no, please explain:
 | [ ]  Yes[ ]  No[ ]  I don’t know |
| Did mother use alcohol or other drugs during pregnancy?* If yes, please explain:
 | [ ]  Yes[ ]  No[ ]  I don’t know |
| Please list any medications taken during pregnancy:       |
| Did the child reach developmental milestones at a normal age *(answer below)*? |
| **Developmental Milestones** |  | **If no, please explain:** |
| Slept through the night | [ ] Yes [ ] No [ ] Do not know |       |
| Sat alone | [ ] Yes [ ] No [ ] Do not know |       |
| Stood alone | [ ] Yes [ ] No [ ] Do not know |       |
| Walked without help | [ ] Yes [ ] No [ ] Do not know |       |
| Said first words | [ ] Yes [ ] No [ ] Do not know |       |
| Spoke in simple phrases | [ ] Yes [ ] No [ ] Do not know |       |
| Toilet trained – day | [ ] Yes [ ] No [ ] Do not know |       |
| Toilet trained - night | [ ] Yes [ ] No [ ] Do not know |       |

| MEDICAL HISTORY: |
| --- |
| Primary Care physician/pediatrician: |       |
| Would you like Innervisions to coordinate care with your PCP? | [ ]  No [ ]  Yes - *(if yes, you will need to fill out a release of information for your PCP)* |
| Please check the appropriate box *(below)* if you have experienced any of these problems: |
| [ ]  Eye disease, injury, poor vision[ ]  Ear disease, injury, poor hearing[ ]  Nose, sinus, mouth, throat problems[ ]  Head injury[ ]  Convulsions or seizures[ ]  Memory problems[ ]  Extreme tiredness or weakness[ ]  Thyroid disease or goiter[ ]  Skin disease[ ]  Heart disease[ ]  Back, arm, leg or joint problems[ ]  Blood disease[ ]  Stomach problems[ ]  Premenstrual Syndrome (PMS)[ ]  Eating disorder[ ]  Liver, gallbladder disease[ ]  Chest pain or angina pectoris | [ ]  Cancer[ ]  Bowel problems[ ]  Hemorrhoids, rectal bleeding[ ]  Loss of consciousness[ ]  Frequent or severe headaches[ ]  Sleep disturbances[ ]  Neck stiffness, pain, swelling[ ]  Marked weight changes[ ]  Circulatory problems[ ]  Allergies or asthma[ ]  Diabetes[ ]  Encephalitis[ ]  Meningitis[ ]  Pregnancy[ ]  High blood pressure[ ]  Other:       |
| * Please explain anything checked above:
 |
| Please provide information about medication(s), prescription or over the counter, which you take regularly: |
| Medication | Dosage/Frequency | Prescribing Physician | For what condition? |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Please list significant hospitalizations, operations, injuries *(including broken bones)*:       |

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| SCHOOL INFORMATION: |
| What school does the child currently attend? |       |
| What is the name of the child’s teacher? |       |
| What grade is the child in? |       |
| How many schools has the child attended? |       |
| * In which cities/towns were the schools located?
 |       |
| Does the child have a written IEP? | [ ]  Yes [ ]  No |
| Is the child in special education classes? | [ ]  Yes [ ]  NoType:       |
| Is the child experiencing any problems in school? |       |
| Academics (grades): | [ ]  Yes [ ]  No |
| Behavior: | [ ]  Yes [ ]  No |
| Social (peers or adults): | [ ]  Yes [ ]  No |
| * Please explain any “yes” responses:
 |       |

| SOCIAL RELATIONSHIPS / FRIENDS: |
| --- |
| How does the child get along with peers? |       |
| How does the child get along with adults? |       |
| Who does the child spend more time with *(check the closest answer)*? | [ ]  Same age children[ ]  Older children[ ]  Younger children[ ]  Adults[ ]  Mostly alone |

| HOME LIFE: |
| --- |
| Is there a behavior problem at home? | [ ]  Yes [ ]  No If yes, please explain below |
| *
 |
| What are the child’s strengths? |       |
| What are the family’s strengths? |       |
| What are the child’s weaknesses? |       |
| What are the family’s weaknesses? |       |
| What kind of discipline is used with the child? |       |
| * Who is the primary disciplinarian?
 |       |
| Are there any family circumstances you would like us to be aware of? |       |
| What goals would you like to see reached as a result of your child’s involvement with Innervisions Counseling? |       |
| How will you know when these goals have been reached *(describe changes in behavior or functioning)*? |       |

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| --- |
| **THERAPIST REVIEW:** |
| Signature: |  |  | Date: |  |
|  |  |  |  |  |