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)*: | | | | |

|  |  |
| --- | --- |
| 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  No  Type: |
| 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)*? |  |

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