GOLDEN SKY
COUNSELING
Rikki Goldenberg, LMHC

Child/Adolescent Parent Intake Questionnaire

Today's Date _____

Name of Child _____ Child's Date of Birth _____

Your Name _____ Relation to Child _____

Who referred you to me? How did you find me as your therapist (e.g., friend recommendation, doctor referral, Google search, provider directory search, etc.)?

_____

_____

What is the reason you are coming in for counseling? Is there something specific, such as a particular event? Please be as detailed as you can.

_____

_____

_____

What are your goals for our work together? What do you hope to gain out of counseling?

_____

_____

_____

Who currently lives in the home with your child? (Name, Relation, Sex, Age) Are there other caregivers in your child's life?

_____

_____

What school does your child attend currently and what kinds of grades do they get in school?

_____

_____

What is the highest grade level your child has completed thus far? _____

Has your child had any disciplinary problems at school?

- ☐ Yes _____
- ☐ No

Social

What does your child like to do for fun or enjoyment? Do they have any hobbies?

_____

_____

_____

Who does your child get along best with?

- ☐ Siblings
- ☐ Peers
- ☐ Younger Children
- ☐ Older Children
- ☐ Adults
- ☐ Other _____

Approximately how many hours per day does your child spend on electronics?

_____

_____

Does your child currently drink alcohol?

- ☐ Yes, how often? _____
- ☐ No

Does your child smoke cigarettes or use any nicotine products?

- ☐ Yes, how often? _____
- ☐ No, I don't use any nicotine products.

Has your child used any recreational drugs in the past 6 months?

- ☐ Yes, how often? _____
- ☐ Have used in the past, but not in the past 6 months
- ☐ Never used

Has your child experienced any legal problems or been arrested?

- ☐ Yes _____
- ☐ No

Medical History

Who is your child's primary care doctor? Please include the doctor's name and phone number.

_____

_____

On a scale from 0 to 10 (0=very poor, 10=the very best), how would you rate your child's health and why?

_____

_____

Please check if your child has experienced any of the following:

- ☐ Migraines
- ☐ Stomach issues
- ☐ Head injury
- ☐ Chest pain
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Other
- ☐ None of the above

Has your child had any major surgeries, illnesses or accidents? if yes, please specify and include the date and what happened.

- ☐ Yes _____
- ☐ No

Does your child have any allergies? If yes, please specify.

- ☐ Yes _____
- ☐ No

Is your child taking any prescription medications?

- ☐ Yes _____
- ☐ No

Developmental and Childhood History

Was your child's pregnancy planned? How did the parents feel about the pregnancy?

_____

_____

_____

Did the mother experience any post-partum depression following the pregnancy?

- ☐ Yes _____
- ☐ No

Was there anything unusual about the child's pregnancy or birth? Any complications?

- ☐ Yes _____
- ☐ No

Where was your child born? _____

Where did your child grow up? _____

What is your view on discipline? What happens if your child breaks the rules or gets into trouble?

_____

_____

Emotional and Behavioral History

Please check any of the following your child has experienced in the past 6 months:

- ☐ Difficulty falling or staying asleep
- ☐ Difficulty getting out of bed
- ☐ Frequent nightmares
- ☐ Changes in eating/appetite
- ☐ Voluntary vomiting
- ☐ Use of laxatives to lose weight
- ☐ Binge eating
- ☐ Excessive exercise to avoid weight gain
- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending more time alone
- ☐ Increased irritability
- ☐ Feeling anxious
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations
- ☐ Repetitive behaviors (counting, checking doors, washing hands)
- ☐ Outbursts of anger
- ☐ Feelings of worthlessness
- ☐ Sadness
- ☐ Fear
- ☐ Tearful or crying spells
- ☐ Hopelessness
- ☐ Low self-esteem
- ☐ Frequent worry
- ☐ Racing thoughts
- ☐ Difficulty catching their breath
- ☐ Easily startled, feeling "jumpy"
- ☐ Difficulty concentrating or thinking
- ☐ Flashbacks of negative events
- ☐ Large gaps in memory
- ☐ Hearing voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or radio is communicating with you
- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Verbal abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Other
- ☐ None of the above

Is there a history of mental illness in your child's family? If yes, please specify their relation to your child as well as their diagnosis if you know it.

- ☐ Yes

  _____

  _____

- ☐ No
- ☐ I'm not sure

Has your child participated in therapy before? If yes, please specify when, the name of the therapist, the reason for seeking help, and if you/they found it helpful.

- ☐ Yes _____
- ☐ No

Has your child ever been hospitalized for a psychiatric issue?

- ☐ Yes _____
- ☐ No

Does your child have, or has your child ever had suicidal thoughts?

- ☐ Yes _____
- ☐ No

Has your child ever attempted suicide? Please list all attempts and your child's age when each happened, starting from the most recent event to the oldest event.

- ☐ Yes _____
- ☐ No

Does your child have, or have they ever had, a problem with self-harm (e.g., cutting, scratching, hair-pulling, etc.)?

- ☐ Yes _____
- ☐ No

Does your child have, or have they ever had, thoughts or urges to harm someone else or damage their property?

- ☐ Yes _____
- ☐ No

Is your child taking any psychotropic medications?

- ☐ Yes _____
- ☐ No

More About Your Child

What are some of your goals for your child over the next 3- 6 months?

_____

_____

_____

What else would you like me to know?

_____

_____

_____