

# FAMILY RESOURCES ASSOCIATES, INC.

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## INTAKE QUESTIONNAIRE – CHILD/ADOLESCENT

Your responses to the following items/questions will help your child/teen's therapist better understand them and their situation in order to provide the best possible service. Please fill out as completely as you can and bring with you to your child/teen's first therapy appointment. The information you provide is confidential and protected by law. Date: \_\_\_\_\_

### IDENTIFYING INFORMATION (for individual receiving services)

Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Parent/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, Zip \_\_\_\_\_ Referred by: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Client's Cell: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

1. Sex:  Male  Female      2. Age: \_\_\_\_\_ Years      3. School: \_\_\_\_\_ Grade: \_\_\_\_\_

4. Teacher/faculty contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

5. Please list any long periods of time your child/teen has been out of school for any reason including major illness, home-schooling, expulsion, etc. \_\_\_\_\_  
\_\_\_\_\_

6. Child/Teen lives with (including parents):

Name	Sex (circle)	DOB & Age (list)	Relationship to Child/Teen
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____

7. If child/teen is not living with one or both birth parents, what is the reason? \_\_\_\_\_  
\_\_\_\_\_

8. Any siblings **not** living in the home:

Name	Sex (circle)	DOB & Age (list)	Reason not living in the home?
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____

9. Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

List any current medications & dosage (including psych meds): \_\_\_\_\_  
\_\_\_\_\_

Past Psychiatric meds: \_\_\_\_\_

Current medical conditions (treated or untreated): \_\_\_\_\_

Date of last physical & Findings: \_\_\_\_\_

Surgeries/Hospitalizations: \_\_\_\_\_

Allergies/Adverse reactions to medications: \_\_\_\_\_

Current Diet/Exercise Routine/Supplements used: \_\_\_\_\_

10. Please provide the following information about the child (as applicable):

Status of parental relationship (pleases check):

Intact  Divorced  Parent(s) deceased  Parents Never Married  Raised by biological parents

Adopted: Age of adoption:\_\_\_\_ Other or explanation of above:\_\_\_\_\_

Father's Name:\_\_\_\_\_ DOB:\_\_\_\_\_ Occupation:\_\_\_\_\_

Address (if different than child/teen's):\_\_\_\_\_ Phone:\_\_\_\_\_

Mother's Name:\_\_\_\_\_ DOB:\_\_\_\_\_ Occupation:\_\_\_\_\_

Address (if different than child/teen's):\_\_\_\_\_ Phone:\_\_\_\_\_

Stepfather's Name:\_\_\_\_\_ DOB:\_\_\_\_\_ Occupation:\_\_\_\_\_

Address (if different than child/teen's):\_\_\_\_\_ Phone:\_\_\_\_\_

Stepmother's Name:\_\_\_\_\_ DOB:\_\_\_\_\_ Occupation:\_\_\_\_\_

Address (if different than child/teen's):\_\_\_\_\_ Phone:\_\_\_\_\_

Foster Parent's Name(s):\_\_\_\_\_ DOB:\_\_\_\_\_ Occupation:\_\_\_\_\_

Address (if different than child/teen's):\_\_\_\_\_ Phone:\_\_\_\_\_

Guardian/Other's Name:\_\_\_\_\_ DOB:\_\_\_\_\_ Occupation:\_\_\_\_\_

Address (if different than child/teen's):\_\_\_\_\_ Phone:\_\_\_\_\_

11. Does the child or any immediate/extended family member have a history of alcohol or drug problems?

Yes  No If yes, please explain: \_\_\_\_\_

12. Does the child or any immediate/extended family member have eating problems?  Yes  No

If yes, please explain: \_\_\_\_\_

13. Has the child or any immediate/extended family member experienced any type of abuse (physical, sexual, domestic or emotional)?  Yes  No If yes, please describe the circumstances:\_\_\_\_\_

14. Financial Status:\_\_\_No problems \_\_\_Some difficulty \_\_\_Great difficulty \_\_\_Bankruptcy Date of Bankruptcy:\_\_\_\_\_

15. Recent major changes/losses (divorce, deaths, serious illness, changing schools, etc.):\_\_\_\_\_

16. Child's Strengths & weaknesses in learning ability:\_\_\_\_\_

17. Activities (hobbies, interests, organized groups, sports, etc.):\_\_\_\_\_

18. 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:\_\_\_\_\_

19. Please describe any involvement your child/teen has had with the legal system (arrests, tickets, truancy, etc.):\_\_\_\_\_

20. Has your child/teen received prior counseling or related services?  Yes  No

If yes, please provide the name of the therapist(s) seen, clinic name, date range of services, reason & outcome:\_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**If child/teen has requested therapy, please allow him/her to answer questions 21-24, helping if needed.**

21. Why did you want to come to counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. What questions do you hope will be answered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Is there any additional information you'd like the therapist to know before your first appointment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Do you have any concerns about alcohol or other substances? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent should complete questions 25-27 & Goals section.**

25. What are your major concerns at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

26. What questions do you hope will be answered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. Is there anything else you want the therapist or counselor to know before the first session? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GOALS**

1. What are your child/teen's strengths? \_\_\_\_\_  
\_\_\_\_\_

2. What are your child/teen's weaknesses? \_\_\_\_\_  
\_\_\_\_\_

3. What goals would you like to see reached as a result of his/her involvement in treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How will you know when these goals have been reached? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child/Teen Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(required if 14 or older)

**Parent/Guardian Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
(required if under 18)

**THERAPIST REVIEW**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**(Page 3 of 3, please be sure to complete all pages)**

**For Office Use Only**

Provider's Initials: \_\_\_\_\_ Admission Date: \_\_\_\_\_ Location: \_\_\_\_\_ Diagnosis Code(s): \_\_\_\_\_

Written Diagnosis: \_\_\_\_\_

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