Child and Adolescent

New Client Intake Questionnaire

**Please fill this questionnaire out completely. It is the information you provide that will help me provide the best mental health services. Honesty and details are important.**

Name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s cell: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/s or Guardian/s Cell: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/s or Guardian/s Cell: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If client is under the age of 13:**

Name of parent/s or Legal Guardian/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***REQUIRED: In cases of parents being separated or divorced a copy of the parenting plan that states who has medical decision-making rights must be attached.***

Who currently lives in your residence (adults & children):

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # | Name | Relation | Gender | Age | # | Name | Relation | Gender | Age |
| 1 |  |  |  |  | 4 |  |  |  |  |
| 2 |  |  |  |  | 5 |  |  |  |  |
| 3 |  |  |  |  | 6 |  |  |  |  |

Why are you coming to counseling, please be specific: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long has this been going on, when did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What made you come in this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to gain from counseling, what goals do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What helps you, what makes things better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have coping skills you currently use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And legal information/issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

Please check any symptoms or experiences you have had and how recently

|  |  |  |  |
| --- | --- | --- | --- |
| **X** | **Symptom or Experience** | **X** | **Symptom or Experience** |
|  | Difficulty falling asleep |  | Difficulty staying asleep |
|  | Difficulty getting out of bed |  | Frequent waking during the night |
|  | Sleeping too much |  | Not feeling rested in the morning |

Average hours of sleep per night: \_\_\_\_\_\_\_\_\_ hours.

|  |  |  |  |
| --- | --- | --- | --- |
| **X** | **Symptom or Experience** | **X** | **Symptom or Experience** |
|  | Loss of interest in previously enjoyed activities |  | Spending increased time alone |
|  | Withdrawing from other people |  | Feeling numb |
|  | Depressed mood |  | Irritability/cranky |
|  | Rapid mood changes |  | Panic attacks |
|  | Anxiety, extra stress, lots of worries |  | Avoiding people, places, activities, or specific things |
|  | Frequent feelings of guilt |  | Outbursts of anger |
|  | Difficulty leaving your home |  | Fear of certain things or situations |
|  | Repetitive behaviors or mental acts (counting, checking doors, washing hands) |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **X** | **Symptom or Experience** | **X** | **Symptom or Experience** |
|  | Worthlessness |  | Hopelessness |
|  | Sadness |  | Helplessness |
|  | Fear |  | Feeling or acting like a different person |

|  |  |  |  |
| --- | --- | --- | --- |
| **X** | **Symptom or Experience** | **X** | **Symptom or Experience** |
|  | Changes in eating or appetite |  | Eating less |
|  | Eating more |  | Use of laxatives |
|  | Voluntary vomiting |  | Binge eating |
|  | Excessive exercise to avoid weight gain |  | Eating somewhat healthy foods |
|  | Are you trying to lose weight \_\_\_yes \_\_\_no |  | Recent weight gain \_\_\_\_\_\_\_lbs. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Difficulty catching your breath |  | Increase muscle tension |
|  | Unusual sweating |  | Easily startled |
|  | Frequent worries |  | Decreased energy |
|  | Racing thoughts |  | Heart palpitations |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Difficulty concentrating or thinking |  | Large gaps in memory |
|  | Flashbacks |  | Nightmares |
|  | Thought of harming or killing yourself |  | Thoughts about harming or killing someone else |

|  |  |
| --- | --- |
| X | **Symptom or Experience** |
|  | Feeling as if you were outside yourself, detached, observing what you are doing |
|  | Intrusive thoughts, impulses or images |
|  | See things that others cannot see |
|  | Hear things that others cannot hear |
|  | Feeling that your thoughts are controlled or placed in your mind |
|  | Feeling that the television, gaming system, or music is communicating with you |

|  |  |  |  |
| --- | --- | --- | --- |
| **X** | **Symptom or Experience** | **X** | **Symptom or Experience** |
|  | Difficulty problem solving |  | Difficulty following through in tasks |
|  | Out of ordinary dependency on others |  | Self-cutting/mutilating |
|  | Inappropriate expressions of anger |  | Difficulty soothing or self-regulating |
|  | Concerns about your sexuality |  |  |

Other symptoms or experiences not mentioned above that you have had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or ( ) I choose not to answer

**Medical:**

Have you previously seen a counselor, therapist, psychologist, psychiatrist or other mental health professional before:

\_\_\_\_Yes \_\_\_\_No

If “yes”:

|  |  |
| --- | --- |
| Name of professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dates of treatment. Month \_\_\_\_\_\_\_\_\_\_ Yr \_\_\_\_\_  Phone number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for seeking help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dates of treatment. Month \_\_\_\_\_\_\_\_\_\_ Yr \_\_\_\_\_  Phone number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for seeking help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Are you currently taking **PRESCRIBED** medication/s: \_\_\_\_\_Yes \_\_\_\_\_No

|  |  |  |
| --- | --- | --- |
| Medication name: | Dose & when | Prescriber Name: |
|  |  |  |
|  |  |  |
|  |  |  |

Add additional pages if needed.

**Non-prescription** over the counter and/or supplements: \_\_\_\_\_Yes \_\_\_\_\_No

|  |  |  |
| --- | --- | --- |
| Medication name: | Dose & when | Prescriber Name: |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever hurt yourself intentionally: \_\_\_\_\_Yes (please describe below) \_\_\_\_\_ No

Please describe how recently, how often, and method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you attempted suicide: \_\_\_\_\_ Yes (please describe below) \_\_\_\_\_No

Please describe how recently, how often, and method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_