

Studio For Change®

3020 N. Lincoln Avenue

Chicago, Illinois 60657

773-281-8130

Child Intake Questionnaire

For clients 18 years of age or younger

Background Information

1. Child/Adolescent's preferred name to be called: _____
2. Gender Identity (circle): Male Female
3. Who should be called regarding scheduling and messages for child? _____
4. Is it OK to leave voice messages on any of the following numbers? (Please check all that apply and provide the preferred phone numbers):
 - a. ___ Home #: _____
 - b. ___ Work #: _____
 - c. ___ Cell #: _____
 - d. ___ Other #: _____
5. Ethnic Identity: _____
6. Primary Language Spoken in the Home: _____
7. Primary Language Spoken by Client: _____
8. Why are you seeking psychotherapy for your child at this time? _____

9. How would you currently rate your child's problem(s) that you are seeking help with at this time? (On a scale from 1-10 with 1=mild and 10=severe) _____
10. How long has the current problem(s) been occurring? _____
11. Please list your child's current coping strategies in dealing with the problem(s): _____

12. What are your child's strengths? _____

13. Is your child currently receiving other services to address the problem (counseling, physical therapy, occupational therapy, services at school, etc)? **Yes No** (circle one)
If yes, what services, where and how often? _____

14. Has your child ever received therapeutic services before? **Yes No** (circle one)
If yes, for what purpose? _____

What services were helpful and why? _____

What services were not helpful and why? _____

Mental Health Information

1. Is your child currently experiencing or has ever experienced suicidal thoughts? **Yes No** (circle one)
If yes, please explain: _____

2. Has your child ever intentionally inflicted harm on him/herself or someone else? **Yes No** (circle one)
If yes, please explain: _____

3. Has your child ever been hospitalized for mental health issues? **Yes No** (circle one)
If yes, please provide when, where and reason: _____

4. Is your child currently seen by a mental health professional? **Yes No** (circle one)
If yes, please provide name/address/phone # of psychiatrist: _____

5. Does your child currently take any medication? **Yes No** (circle one)
If yes, please list medication with dosage: _____

6. Does your child currently have a formal Mental Health diagnosis? **Yes No** (circle one)
If yes, what diagnosis: _____

Who was the diagnosing practitioner? _____

Developmental/Medical Health

1. Please describe any developmental history or concerns you have or had with your child (pregnancy, milestones, motor skills, speech and language): _____

2. Does your child have any major illnesses or long-term medical problems? **Yes No** (circle one)
Please explain: _____
3. Does your child require assistance in daily living activities (i.e. getting dressed, eating, toileting, walking, etc)? **Yes No** (circle one)
If yes, please explain: _____

4. Does your child have any difficulties with sleep? **Yes No** (circle one)
If yes, please explain: _____

5. Does your child have any issues related to eating? **Yes No** (circle one)
If yes, please explain: _____

6. Does your child have consistent weekly activity? **Yes No** (circle one)
If yes, please explain: _____
7. Who is your child's physician (please provide name/address/phone #)? _____

Social History

1. Does your child attend school? **Yes No** (circle one)
If yes, please provide school name, address, phone #: _____

What grade is your child in? _____
Is your child in a full-time regular classroom? _____
Does your child receive supportive services from school? **Yes No** (circle one)
If yes, what services and how often? _____

2. Does your child have any learning issues or disabilities? **Yes No** (circle one)
If yes, please describe: _____

3. Does your child have any issues related to socialization (i.e. difficulty making/maintaining friends, lack of significant peer group, exhibit anti-social behaviors)? **Yes No** (circle one)
If yes, please describe: _____

4. Please list your child's participation in extra-curricular activities: _____

5. Please list your child's hobbies or areas of interest: _____

6. Please list all of your child's volunteer positions or jobs (i.e. babysitting, dog walking, paper route, etc)?

Substance Use

1. Does your child smoke cigarettes? **Yes No** (circle one)
2. Does your child drink alcohol or take any recreational drugs? **Yes No** (circle one)
If yes, please describe: _____
3. Do you have any concerns related to your child and substance abuse? **Yes No** (circle one)
If yes, please explain: _____

4. Does anyone in your child's family currently have or has had in the past a substance abuse problem?
Yes No (circle one)
If yes, please describe: _____

Family Background

1. Please list current members of your family:

Name	Age or Date of Birth	Occupation or Year in School	Currently living with Client? (yes or no)

2. Please list any information about your child's family and relationships (i.e. divorce, extended family, past abuse experienced or witnessed by child, etc.): _____

3. Have any family members experienced and/or been diagnosed with a Mental Health Disorder?
Yes No (circle one)
If yes, please explain: _____
4. Have any family members experienced and/or been diagnosed with any learning issues or disabilities?
Yes No (circle one)
If yes, please explain: _____

Legal Concerns

1. Is your child or any immediate family members currently involved in any court case? **Yes No** (circle one)
If yes, please describe: _____

2. Are you currently involved in divorce mediation or a custody case? **Yes No** (circle one)
If yes, please describe: _____

3. Is there currently a custody agreement in place? **Yes No** (circle one)
If yes, please describe agreement (please note: the Studio For Change needs a copy of the custody agreement for your child's file): _____

Please list anything else you would like your Studio For Change therapist to know about your child or family before you initiate therapy:
