

**CHILD/ADOLESCENT INTAKE SUMMARY**  
**(Parent Questionnaire)**

I. Brief Statement of Reason for Seeking Services: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred By: \_\_\_\_\_

Your goals/hopes for treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Previous Mental Health Treatment:

A. Outpatient Services:(include names of clinicians, dates of treatment and nature of problem)

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

B. Has your child ever been in a hospital for mental health/emotional problems? If so: When? Where?

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

C. Has your child ever been on medication for emotional/behavioral problems? If so: What? When?

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

III. Medical History:

A. Current primary care physician (pediatrician or family physician):

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

B. Current ( or significant past ) medical problems for which your child is/has been treated:

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

C. Current Medications/dosages: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

D. Has your child ever had to undergo surgery? Sustained any significant injuries (e.g. head injury, broken bones)? Lost consciousness? Had a seizure? If so, describe:

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

E. Were there any problems during pregnancy or delivery? Developmental milestones met on time?

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

F. Does your child smoke? Do you know of /suspect drug or alcohol use?

\_\_\_\_\_

G. Is there a family history of medical or mental health problems? Describe:

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

H. Is there any other medical information you feel is important?

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

IV. Psychosocial Information:

A. *Education:* School: \_\_\_\_\_ Grade \_\_\_\_\_  
Primary Teacher: \_\_\_\_\_ Guidance Counselor: \_\_\_\_\_

Does your child receive special ed services? Has s/he had to repeat any grades? If so, describe:

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

B. *Spiritual Life:* Denomination: \_\_\_\_\_ Church: \_\_\_\_\_  
Pastor: \_\_\_\_\_ Youth Minister: \_\_\_\_\_

How important is religion in your child's/family's life? \_\_\_\_ Very \_\_\_\_ Somewhat \_\_\_\_ Not at All

C. Has your child ever been involved with the law? If so, describe:

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

D. What do you consider to be the most significant stressors your child has had to face in his/her life?  
Has s/he had to face abuse, death of a loved one, peer ridicule, separation/divorce?

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

E. Other (Use this space to add additional information you think is important):

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

Thank you for the time and attention you have devoted to this form  
It will help us to better serve you and your family.