INTAKE QUESTIONNAIRE – CHILD

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: Date:

Child is (check one): ◯ biological child ◉ adopted child ◯ foster child Other:
Are there any custodial issues?: ◯ Yes ◉ No

IDENTIFYING INFORMATION (for Child receiving services)

Child's Birth / Legal Name: Date of Birth:

Address: Sex:

Work Phone (indicate whose #):

Home Phone:

Who referred you to LGWC?

1.) Do you or the child have a disability? ◯ Yes ◯ No If yes, please specify:

If you have a disability, does the office accommodate your needs? ◯ Yes ◯ No

If no, please explain:

2.) 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:

PRESENTING PROBLEM (current situation and history)

Please **rate on a scale of 1 – 5** any of the reasons listed below which led you to seek treatment, **Check up to the 3 most important**: (**1**-Very Mild **2**-Somewhat Mild **3**-Moderate **4**-Somewhat Severe **5**-Severe)

- ☐ CIICK Depression or anxiety
- ☐ CIICK Worry about drinking or drug use
- ☐ CIICK Communication problems
- ☐ CIICK Arguing with parent(s)
- ☐ CIICK Arguing with brothers/sisters
- ☐ CIICK Sexual orientation questions
- ☐ CIICK Problematic or too much anger
- ☐ CIICK Feel alone/trouble making friends
- ☐ CIICK Trouble controlling impulses
- ☐ CIICK Difficulty with loss or death
- ☐ CIICK Trouble staying organized
- ☐ CIICK Trouble concentrating
- ☐ CIICK Thinking of hurting myself or someone else
- ☐ CIICK Learning/memory problems
- ☐ CIICK Family problems
- ☐ CIICK Abuse (physical/sexual/emotional/verbal)
- ☐ CIICK Trauma - *Nature:*
- ☐ CIICK Individual counseling
- ☐ CIICK Family member wants me here
- ☐ CIICK Getting in trouble at school
- ☐ CIICK Learning problems
- ☐ CIICK Trouble following directions
- ☐ CIICK Other:

3.) Is there anything else you want the therapist or counselor to know before your first session?

FAMILY HISTORY

1. With whom does the child currently live (names and relationship)? _____

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

Father's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

Mother's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

Stepfather's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

Stepmother's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

Foster Father's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

Foster Mother's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

Guardian/Other's Name: _____ Phone #: _____

Address: _____

D.O.B.: _____ Occupation: _____ Involvement Some○ Minor○ None○

3. Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (full, half, step, foster)	Lives with Child?	If no, lives where?
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	
			◯ Yes ◯ No	

4. Does the child or any other family member have a history of alcohol or drug problems? ◯ Yes ◯ No

   If yes, please explain:

5. Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? ◯ Yes ◯ No If yes, please describe the circumstances:

LEGAL HISTORY

Please describe any involvement the child has had with the legal system (arrests, convictions, probation, parole, Etc.):

DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal? ◯ Yes ◯ No ◯ I don't know

   If no, please explain:

2. Did mother use alcohol or other drugs during pregnancy? ◯ Yes ◯ No ◯ I don't know

   If yes, please explain:

3. Please list any medications taken during pregnancy:

4. Did the child reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				

MEDICAL HISTORY

Previous Mental Health Treatment

	YES/NO	When	Where	Outcome
Counseling?	○ Yes ○ No			
Psychiatric Treatment?	○ Yes ○ No			
Past/Current Diagnosis?	○ Yes ○ No			
Self Injury?	○ Yes ○ No			
Suicidal Thoughts?	○ Yes ○ No			
Suicide Attempt?	○ Yes ○ No			
Danger to Others?	○ Yes ○ No			

MEDICAL HISTORY

Name and address of family Physician

Date of last physical examination

List any past or present illnesses, infirmities or disabilities of any consequence:

Please list significant hospitalizations, operations, injuries (including broken bones):

Medications Child is taking?

Please rate the severity of any current or recent (within the past 6 months) symptoms or problems by assigning either a 1, 2, 3, 4 or 5 from the following scale:

1- Very mild **2**-Somewhat mild **3**-Moderate **4**-Somewhat Severe **5**-Severe

CIICK a. anxiety, tension, nervousness
CIICK b. coldness or numbness in fingers
CIICK c. frequent or severe headaches
CIICK d. skin problems (i.e. rash, acne or dermatitis)
CIICK e. frequent upset stomach/ indigestion/ nausea
CIICK f. depression or crying spells
CIICK g. chronic pain (specify_____)
CIICK h. dizziness or fainting spells
CIICK i. diarrhea or constipation/ urinary problems
CIICK j. memory problems/ inability to concentrate
CIICK k. excessive alcohol, drug or medication use
CIICK l. excessive caffeine use (e.g. coffee, tea, chocolate, soda)
CIICK m. high blood pressure/ hypertension
CIICK n. muscle tension/ spasticity/ cramps
CIICK o. heart palpitations or pounding
CIICK p. frequent worrying/ preoccupation
CIICK q. stiffness, aching or burning sensation in joints
CIICK r. lack of energy/ frequent fatigue or sluggishness
CIICK s. lack of appetite
CIICK t. excessive appetite
CIICK u. shortness of breath/ rapid breathing
CIICK v. problems with falling asleep
CIICK w. frequent wakening/ early wakening
CIICK x. excessive energy/ hyperactivity
CIICK y. sexual functioning problems
CIICK z. irritability/ temper control problems
CIICK Other:_____

SCHOOL INFORMATION

1. What school does the child currently attend? _____
2. What is the child's teacher's name? _____
3. What grade is the child in? _____
4. How many schools has the child attended? _____
   In which cities/towns were they located? _____
5. Does the child have a written IEP? ◯ Yes ◯ No
   Is the child in special education classes? ◯ Yes ◯ No Type: _____
6. Is the child experiencing any problems in school?
   Academics (grades): ◯ Yes ◯ No
   Behavior: ◯ Yes ◯ No
   Social (peers or adults): ◯ Yes ◯ No

   Please explain any "yes" responses:

SOCIAL RELATIONSHIPS / FRIENDS

1. How does the child get along with peers?

2. How does the child get along with adults?

3. Does the child spend more time with (check the closest answer):
   - ☐ Same age children
   - ☐ Older children
   - ☐ Younger children
   - ☐ Adults
   - ☐ Mostly alone

4. What are the child's hobbies and interests?

HOME LIFE

1. Is there a behavior problem at home? ◯ Yes ◯ No If yes, please explain:

2. What are the child's strengths?

3. What are the family's strengths?

4. What are the child's weaknesses?

5. What are the family's weaknesses?

6. What kind of discipline is used with the child?

   Who is the primary disciplinarian?

7. Are there any family circumstances you would like us to be aware of?

8. What goals would you like to see reached as a result of (your child) attending counseling?

9. How will you know when these goals have been reached (describe changes in behavior or functioning)?

THERAPIST REVIEW

Signature:_____ Date: _____

Supervising Signature: _____ Date: _____

Policy on Divorce and/or Custody Cases

We are not custody evaluators and cannot make any recommendations on custody or visitation. Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies to which you must agree before we enter a counseling relationship

a) We require a copy of any most current standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session.

b) In most cases we need to have contact and written/signed consent with/from both legal guardians before we see the child for counseling. In the case there is a final decision-maker on health related issues, with one parent who wants the child to be seen for counseling even in the case where the other parent does not agree, it is to the discretion of your therapist as to whether the child will be seen.

c) We will provide a phone interview with any court-ordered Guardian ad Litem (GAL) and/or custody evaluator (CE) whom the court has ordered will have access to the child's records and any time spent speaking with the GAL or CE will be billed to and paid by you, the client at our court-related-fee hourly rate.

d) We will be in equal contact with both parents who share in the legal custody of the child being seen for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way at either the beginning or end of the session.

e) Family sessions may be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

f) We require all clients waive right to subpoena any of our

therapists to court. By signing this agreement you are acknowledging and agreeing NOT to have us subpoenaed to court. This policy is set in order to preserve the integrity of the therapeutic progress and relationship with you and/or your child(ren).

g) In the case that the above policy regarding subpoenas and court is waived (or disregarded) and we are subpoenaed to appear in court—even with a waiver of this policy—you will be billed for the full standard fee for Court Related work of
$200/hour for all professional time. Any time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the courthouse in addition to time on the stand as well as any travel time will be billed at $200 per hour.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, check the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	☐ 0	1	☐ 2	☐ 3	☐ 4	
	2.	Said he/she was worried about his/her health or about getting sick?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV.	5.	Had less fun doing things than he/she used to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	6.	Seemed sad or depressed for several hours?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8.	Seemed angry or lost his/her temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10.	Slept less than usual for him/her, but still had lots of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	12.	Not been able to stop worrying?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	◉ Yes	○ No	○ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	○ Yes	◉ No	○ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	◉ Yes	○ No	○ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	◉ Yes	○ No	○ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	○ Yes	○ No	◉ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	○ Yes	○ No	○ Don't Know			

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: HERE **This is your ACE Score**