☐ Lake Geneva Wellness Clinic, LLC
101 Broad Street Suite 201
Lake Geneva WI 53147
262-248-7942

☐ Wheatland Location
6606 368th Ave
Burlington, WI 53105

# *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 (circle one): my biological child my adopted child my 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, **circling up to the 3 most important**: (**1**-Very Mild **2**-Somewhat Mild **3**-Moderate **4**-Somewhat Severe **5**-Severe)

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

_____a. anxiety, tension, nervousness
_____b. coldness or numbness in fingers
_____c. frequent or severe headaches
_____d. skin problems (i.e. rash, acne or dermatitis)
_____e. frequent upset stomach/ indigestion/ nausea
_____f. depression or crying spells
_____g. chronic pain (specify_____)
_____h. dizziness or fainting spells
_____i. diarrhea or constipation/ urinary problems
_____j. memory problems/ inability to concentrate
_____k. excessive alcohol, drug or medication use
_____l. excessive caffeine use (e.g. coffee, tea, chocolate, soda)
_____m. high blood pressure/ hypertension
_____n. muscle tension/ spasticity/ cramps
_____o. heart palpitations or pounding
_____p. frequent worrying/ preoccupation
_____q. stiffness, aching or burning sensation in joints
_____r. lack of energy/ frequent fatigue or sluggishness
_____s. lack of appetite
_____t. excessive appetite
_____u. shortness of breath/ rapid breathing
_____v. problems with falling asleep
_____w. frequent wakening/ early wakening
_____x. excessive energy/ hyperactivity
_____y. sexual functioning problems
_____z. irritability/ temper control problems
_____ 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 ☐ Adults
   ☐ Older children ☐ Mostly alone
   ☐ Younger children

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: _____