899 Logan Street, Suite 307
Denver, CO 80203
(303) 756 1197

CHILD INTAKE QUESTIONNAIRE

Client Information

Name: _____

Date of Birth: _____ Age: _____

Sex at Birth:
- ❑ Male
- ❑ Female
- ❑ Intersex
- ❑ _____

Gender:
- ❑ Male
- ❑ Female
- ❑ Trans- Female
- ❑ Trans-Male

- ❑ Agender
- ❑ Non-binary
- ❑ Gender Queer
- ❑ Gender Questioning
- ❑ _____

Parents' or Guardians' Names _____

Parents' or Guardians' Occupations_____

Preferred Title:
❑ Dr. ❑ Mrs. ❑ Mr. ❑ Ms. ❑ _____

*Are parents married? _____If not, please describe current custody and medical decision making arrangements:

_____

Address: _____

_____

What **school** is your child currently attending? _____

What **grade** is your child currently attending? _____

Relevant Phone #'s: _____
(include cell numbers, work numbers, or wherever is easiest to reach you)
Describe any confidentiality considerations you would like us to take when using the above contact numbers:

Referred by: _____
I often thank referrals for sending you my way. Is this okay with you? _____
(This only applies to other providers- not friends or past clients)

Emergency Contacts
Name of one or more emergency contacts and relationship(s) to you:
_____

Phone #'s: _____

Insurance Information

If you plan to use your insurance to get reimbursed for services, please complete the information below.

Primary Insurance Information:
Insurance Company Name: _____ID #: _____ Group #_____

Policy Holder Name: _____Policy Holder DOB: _____Policy Holder SS #: _____

Secondary Insurance Information:
Insurance Company Name: _____ID #: _____ Group #_____

Policy Holder Name: _____Policy Holder DOB: _____Policy Holder SS #: _____

Family History and Cultural Information

Office Use Only

Please list all family member's living in your child's home and the relationship to your child.

Name	Gender	Age	Relationship

If your child has siblings, how would you describe the relationship between your child and his or her siblings?

How would you describe your family's religious values? Does your child have similar values? Please describe:

What cultural/ethnic group do you include you or your child in? _____
What does your affiliation with this group mean to your family?

Languages spoken within the home?
Child's primary language:
Child's secondary language:
Primary languages spoken by parents:
Any additional information pertaining to language acquisition/exposure including dual-language schools?

How would you describe your child/adolescent?	

Current Concerns **Office Use Only**

Please describe the primary concerns or goals you have for your child:	
Concern/goal #1	
Concern/goal #2	
Concern/goal #3	
What steps have you taken to address these concerns in the past? What has worked? What has not worked?	
What prompted you to seek services now?	

Developmental Section **Office Use Only**

Please provide information regarding pregnancy and delivery of your child.	

Weeks' gestation _____ Medications used by mother during pregnancy? _____ In utero exposure to drugs/alcohol/tobacco/marijuana, etc. _____	
Complications? _____ _____ APGAR score? _____ Condition at birth? _____ Other relevant information? _____	
Please provide information regarding your child's development by providing the approximate age when each of the following was achieved independently. If your child has not yet acquired the skill, please note that as well. Rolled over _____ Sat up _____ Stood up _____ Crawled _____ Walked _____ Spoke first words_____ What were they? _____ Put two words together _____ Demonstrated understanding of simple directions _____ Read words _____ Wrote words _____ Used a crayon to color _____ Was toilet trained during the day _____ Was toilet trained at night _____ Made eye contact with others_____ Engaged in interactive play_____ Identified someone as a best friend _____ Started showing physical signs of puberty _____	
Has your child ever shown a regression in developmental skills or lost a skill once he or she acquired it? If so please describe.	
Does your child demonstrate any repetitive behaviors? If so please describe.	

Does your child regularly integrate nonverbal means of communication such as nodding, gestures, eye contact, and varied facial expressions?	
Does your child have difficulties with attention, concentration, or hyperactivity? If so, when did these problems first arise?	
Has anyone in your family ever been diagnosed with a developmental disorder or developmental delay?	

Physical Health **Office Use Only**

Please list any major physical illnesses, accidents, hospitalizations, and surgeries in your child's medical history along with dates and ages.	
List all major or chronic illnesses with dates and ages _____ _____ _____ Still experiencing symptoms? _____ _____ Lasting effects? _____	
Please describe any major accidents or falls along with dates and ages____ _____ _____ Did any result in a head injury or concussion? _____ Any changes in behavior or cognitions following the injury? _____ If so please describe changes and duration. _____ _____	
Please describe any hospitalizations and/or major surgeries along with dates and ages _____ _____ Any lasting problems or pain? _____	

Is your child currently experiencing any chronic pain? If so, please describe the pain, intensity, duration, and cause.

Please provide information regarding any current or past medications that your child has taken for an extended period of time. It is especially important to include all medications that are related to your current concerns.

Medication	Dates taken	Dosage	Purpose	Effective?

Name of current prescribing physician or psychiatrist_____

How many hours of sleep does your child get per night? _____
Describe any difficulties with sleep:

How would you describe your child's eating habits?

Any recent weight gains/losses not related to growth?

How does your child feel about his/her weight?

Describe your child's attitude toward and involvement in physical exercise:

How do you feel about your child's physical condition?

Are there any concerns with your child's vision or hearing? If so, describe:

Do you or your child have any difficulties with motor skills or coordination? If so describe:

Does your child have any sensory sensitivities? Is there excessive avoidance of some sensory stimulation or any excessive sensory seeking behaviors? If so, please describe:	
Does your child use drugs, alcohol, or cigarettes? If so, please describe the frequency of use.	

Social **Office Use Only**

How would you describe your child's friendships, including the quantity and quality of these relationships?	
Does your child have difficulty making or keeping friends? If so, describe these difficulties.	
How does your child spend social time? What kinds of activities does your child enjoy? What does your child do for fun (e.g. hobbies, interests)?	

Psychological **Office Use Only**

Has your child ever been diagnosed with a mental health disorder? If so, please describe current symptoms.	
Has your child ever had psychological testing completed? If so, describe results and include the person/agency who conducted the testing.	
Has anyone in your family ever been diagnosed with a mental health disorder? Please indicate family member and diagnosis.	
Describe any past therapy experiences (include dates). What worked or didn't work?	

Has your child ever been psychiatrically hospitalized? (If yes, where and when?):	
Please describe your child's typical mood:	
Please describe your/your child's personal strengths:	
Please circle any of the following that your child experienced in the last 6 months: Increased/decreased appetite Isolating from others Loss of Interest Feeling empty Hopelessness Crying spells Increased fears Sleep problems Short attention span Increased anger Abuse of alcohol/drugs Feeling paranoid Increased irritability Nervousness Panic attacks Easily frustrated Low self-esteem Anxiety Increased fatigue Self-hate Confusion Seeing things that others don't Lack of energy/lethargy Repetitive behavior Relationship issues Recurring thoughts Extreme worry Nightmares Flashbacks Too much energy Trouble concentrating Sexual issues Memory problems Racing thoughts Mood swings Violent actions Change in weight Feeling stressed Depressed mood Unusual/extreme euphoria Recklessness Procrastination Hearing voices that others don't Disorientation	
Do you feel that you/ your child experiences difficulties with coping skills?	

Please describe things that your child does to cope with stressors?	
Has your child ever engaged in self-harm such as cutting, head banging, or any other purposeful injury to self?	
Do you feel that your child has a difficult time controlling his or her anger? Has your child ever become violent with another person? If so, when and what situation?	
Has your child ever spent time in jail, prison, or detention? If so, when and for what crime?	
Has your child had any suicidal thoughts or history of attempted suicide?	

Education **Office Use Only**

How would you describe your/your child's experience in school?	
Is there a history of learning problems? If so, describe:	
Has your child had any previous educational testing? (through tutoring centers, school, Child Find or early intervention)? If yes, please describe the type of testing received: Diagnosis? What recommendations were made as a result of the evaluation?	
Has your child ever had an **IEP** (Individual Education Program)? If yes, date of last IEP review and under what disability (speech-language; specific learning disorder; other health impairment; ADHD; autism spectrum disorder (ASD); developmental delay; etc.):	
Has your child ever had a 504 plan? If yes, date of last 504 review and for what purpose:	

Has your child ever had been involved in an ALP (Accelerated Learning Program) or Gifted/Talented Programming?	
Has your child ever repeated a grade?	
Please describe any suspensions/detentions:	
Please describe family values towards school and education:	
Has anyone in your family been diagnosed with a learning disability or other disability that affects learning?	

Environmental **Office Use Only**

Describe any environmental trauma your child may have experienced (e.g., tornados, floods, hurricanes, etc.):	
Describe any sexual/physical/mental abuse:	
Has your child ever been the victim of a violent crime? If so describe:	
Please describe any significant environmental stressors that have affected your child.	

Describe any past family Dept. of Human Services involvement: Describe any current family Dept. of Human Services involvement: Does your family currently have a caseworker?	

We have asked you a lot of questions, however, is there any additional information that you feel would be important to add?

Please sign below to indicate that the above information is accurate to the best of your knowledge.

Client Signature (if 15 years or older)_____ Date_____

Parent/Guardian of Client (if younger than 15) _____ Date_____