



Child Intake Questionnaire

Date: _____

Name of person completing form: _____ Relation to minor: _____

General Info

Child's Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Home Phone: _____ OK to leave messages at this phone number? Yes No

Cell Phone: _____ OK to leave messages at this phone number? Yes No

Address: _____

City: _____ State: _____ ZIP: _____

OK to send mail to this address? Yes No

Siblings of minor (names & ages): _____

Guardian #1 Name: _____

Relation: _____ Date of Birth: _____

Guardian currently employed: Yes No Hours per week: _____

Place of Employment: _____ Job Title: _____

Relationship Status: _____

Home Phone: _____ OK to leave messages at this phone number? Yes No

Cell Phone: _____ OK to leave messages at this phone number? Yes No

Work Phone: _____ OK to leave messages at this phone number? Yes No

Preferred number for contact: _____

Email: _____ OK to send emails to this email address? Yes No

Address: _____

City: _____ State: _____ ZIP: _____

OK to send mail to this address? Yes No

Who lives in the household (names, ages, relation): _____

Does this guardian have legal custody of the client? Yes No JOINT or SOLE (circle one)

Does this guardian have physical custody of the client? Yes No JOINT or SOLE (circle one)



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Guardian #2 Name: _____

Relation: _____ Date of Birth: _____

Guardian currently employed: Yes No Hours per week: _____

Place of Employment: _____ Job Title: _____

Relationship Status: _____

Home Phone: _____ OK to leave messages at this phone number? Yes No

Cell Phone: _____ OK to leave messages at this phone number? Yes No

Work Phone: _____ OK to leave messages at this phone number? Yes No

Preferred number for contact: _____

Email: _____ OK to send emails to this email address? Yes No

Address: _____

City: _____ State: _____ ZIP: _____

OK to send mail to this address? Yes No

Who lives in the household (names, ages, relation): _____

Does this guardian have legal custody of the client? Yes No JOINT or SOLE (circle one)

Does this guardian have physical custody of the client? Yes No JOINT or SOLE (circle one)

If joint physical custody exists, please outline custody arrangements: _____

Name of parent(s) if not listed above: _____

Describe visitation/ involvement with parents if not listed as guardians:

Emergency Contact: _____

Relationship: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone No. & Type: _____

Phone No. & Type: _____



Minor's Primary Physician: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Intended payment method for treatment (private pay, insurance, etc): _____

If utilizing insurance:

Name of Insurance Company: _____

Policy No.: _____ Group No.: _____

Plan Code: _____ Co-Payment: _____

Subscriber (Name of primary insured): _____

SSN: _____ Relation to client: _____

Member Services Phone: _____

Education

Minor's current grade: _____ Current school: _____

Does minor have an IEP or receive any accommodations/ special services at school: Yes No

Please describe: _____

Has minor ever repeated a grade: Yes No If yes, what grade(s): _____

Circumstances that lead to minor repeating grade: _____

Concerns with minor's academic performance at school: Yes No

Please describe: _____

Concerns with minor's behavior at school: Yes No

Please describe: _____

Concerns with minor's social functioning at school: Yes No

Please describe: _____



Areas of Concern

What issues/concerns cause you to seek treatment for the minor at this time?

Do you or minor have any specific goals/outcomes in mind with regard to treatment?

Do you or minor have any particular concerns/ fears with regard to treatment?

Psychiatric History

Has minor ever been diagnosed with a mental health condition: Yes No

Please list diagnoses, date diagnosed, and who provided diagnoses:

Has minor participated in outpatient mental health treatment before: Yes No

When and for how long? _____

What was the focus of treatment? _____

Do you believe treatment was beneficial? Please describe: _____



Name of treating Therapist/ Physician, address, and phone number:

Has minor ever been hospitalized for psychiatric/ psychological issues: Yes No

When and for how long? _____

For what condition(s) was minor hospitalized? _____

Is minor currently taking any medications for psychiatric/ psychological issues: Yes No

Prescribing Physician: _____

List medications, dosages, and reason for taking them:

Is minor currently taking any other medications, prescribed and/or over the counter: Yes No

List medications and reasons for taking them:

Has minor ever participated in a drug treatment or 12-Step program? Yes No

Please describe: _____

Does minor drink caffeine: Yes No

What kind of caffeinated drinks? _____

How much? _____ For how long? _____

Does minor use tobacco products? Yes No

What kind of products? _____

How much? _____ For how long? _____

Does minor drink alcohol? Yes No

How much? _____ For how long? _____



Do you know if minor used any other substances in the last 12 months: Yes No

What has minor used? _____

Has minor experienced any recent loss, major changes, or stressors in his/ her life: Yes No

Please describe: _____

Has minor ever attempted suicide: Yes No When? _____

Describe the circumstances surrounding previous attempt(s): _____

Is minor currently expressing suicidal thoughts: Yes No

Please describe: _____

History of mental illness, substance abuse, or suicide in family: Yes No

Please describe: _____

Medical History

Has minor ever been diagnosed with a chronic or serious illness/ condition: Yes No

Please describe: _____

Does minor have any medical conditions that may affect mental health treatment? Yes No

Please describe: _____



Is minor experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Yes No

Please describe: _____

Other information

Has minor ever been subjected to verbal, physical, emotional, or sexual abuse: Yes No

Please describe: _____

Has minor ever been a victim of a violent crime: Yes No

Please describe: _____

Has minor ever been arrested: Yes No

Please describe: _____

Are you or minor now, or have you or minor ever been involved in a lawsuit: Yes No

Please describe: _____

Please describe any significant events, changes or incidents that have occurred in minor's life, not already mentioned:

Please describe your spiritual beliefs & practices, and minor's if different:



Please describe minor's interests & hobbies:

Does minor or your family belong to any communities (church, interest clubs, athletic teams, etc):

Please describe minor's personal strengths:

Please describe strengths of the family:

Is there anything else you'd like to share related to minor's history or mental health treatment?
