GRANGER MEDICAL CLINIC

Child Intake Questionnaire

Identification Information

Child's Name: _____

DOB: _____ Age: _____

Person completing this form: _____ Relationship to Child: _____

Child's Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Choose One: ☐ Work ☐ Home ☐ Cell

Do we have permission to leave a message for you at the above number? ☐ Yes ☐ No

Emergency Contact Name and Phone #: _____

Family Information

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Other Parental Figure: _____ Age: _____ Occupation: _____

Please describe the child's relationship with his/her mother: _____

_____

Please describe the child's relationship with his/her father: _____

_____

Marital status of child's parents: _____

Who does your child currently live with?

Name	Age	Relationship to Child	Occupation/Grade

Significant others NOT currently living with your child:

Name	Age	Relationship to Child	Occupation/Grade

Who in the family is your child closest to?_____

Has anyone in the family been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, please describe:_____

_____

_____

What would you say are some of the strengths and weakness of your family?_____

_____

_____

What else would be important for us to know about your child or family?_____

_____

_____

_____

Education Information

What school does your child attend?_____

Current Grade:_____

Favorite Subject:_____ Least Favorite Subject:_____

Has your child been retained or skipped a grade? ☐ Yes ☐ No

If yes, please provide more information:_____

_____

Medical History

Name of Pediatrician:_____

Other medical providers involved in your child's care:_____

_____

Please list major medical conditions your child has been diagnosed with, including chronic illnesses, disabilities, and mental health concerns:

_____

_____

_____

Please list your child's current medications:_____

_____

_____

Were there any complications or difficulties during pregnancy or childbirth? ☐ Yes ☐No

If yes, please explain: _____

_____

_____

Previous Treatment

Has your child received counseling, psychological, or psychiatric services before? ☐ Yes ☐No

If yes, please provide the following information:

When	Name of Treating Professional	Reason for Treatment	Outcome

Other History

Has your child experienced any major emotional losses (e.g. death or separation from a close family member or caretaker)? ☐ Yes ☐ No

If yes, please explain: _____

_____

Has your child experienced abuse, including physical, emotional, or sexual? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

What behaviors are you concerned about?_____

_____

_____

Please list some of your child's strengths: _____

_____

_____

_____

What goals do you hope to accomplish during therapy? _____

_____

_____

_____

What are your child's goals for therapy? _____

_____

_____