FAMILY RESOURCES ASSOCIATES, INC.

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INTAKE QUESTIONNAIRE – CHILD/ADOLESCENT

Your responses to the following items/questions will help your child/teen's therapist better understand them and their situation in order to provide the best possible service. Please fill out as completely as you can and bring with you to your child/teen's first therapy appointment. The information you provide is confidential and protected by law. Date:_____

IDENTIFYING INFORMATION (for individual receiving services)

Client:_____DOB:_____Parent/Guardian's Name:_____

Address:_____City, Zip_____Referred by:_____

Home Phone:_____Parent Cell:_____Client Social Security Number:_____

1. Sex: _ Male _ Female 2. Age: ___ Years 3. School: _____ Grade: ____

4. Teacher/faculty contact:_____Phone Number:_____

5. Please list any long periods of time your child/teen has been out of school for any reason including major illness, home-schooling, expulsion, etc. _____
_____

6. Child/Teen lives with (including parents):

Name	Sex (circle)	DOB & Age (list)	Relationship to Child/Teen
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____

7. If child/teen is not living with one or both birth parents, what is the reason? _____
_____

8. Any siblings **not** living in the home:

Name	Sex (circle)	DOB & Age (list)	Reason not living in the home?
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____
_____	Male Female	_____	_____

9. Primary Physician:_____City:_____Phone:_____

List any current medications & dosage (including psych meds): _____
_____

Past Psychiatric meds:_____

Current medical conditions (treated or untreated):_____

Date of last physical & Findings:_____

Surgeries/Hospitalizations:_____

Allergies/Adverse reactions to medications:_____

Current Diet/Exercise Routine/Supplements used:_____

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

Status of parental relationship (pleases check):

__Intact __Divorced __Parent(s) deceased __Parents Never Married __Raised by biological parents

__Adopted: Age of adoption:___ Other or explanation of above:_____

Father's Name:_____DOB:_____Occupation:_____

Address (if different than child/teen's):_____Phone:_____

Mother's Name:_____DOB:_____Occupation:_____

Address (if different than child/teen's):_____Phone:_____

Stepfather/Sig. Other Name:_____DOB:_____Occupation:_____

Address (if different than child/teen's):_____Phone:_____

Stepmother/Sig. Other Name:_____DOB:_____Occupation:_____

Address (if different than child/teen's):_____Phone:_____

Foster Parent's Name(s):_____DOB:_____Occupation:_____

Address (if different than child/teen's):_____Phone:_____

Guardian/Other's Name:_____DOB:_____Occupation:_____

Address (if different than child/teen's):_____Phone:_____

11. Does the child or any immediate/extended family member have a history of alcohol or drug problems?

☐ Yes ☐ No If yes, please explain: _____

_____

12. Does the child or any immediate/extended family member have eating problems? ☐ Yes ☐ No

If yes, please explain: _____

13. Has the child or any immediate/extended family member experienced any type of abuse (physical, sexual, domestic or emotional)? ☐ Yes ☐ No If yes, please describe the circumstances:_____

_____

14. CaregiverFinancial Status:__No problems__Some difficulty__Great difficulty__Bankruptcy/Date:_____

15. Recent major changes/losses (divorce, deaths, serious illness, changing schools, etc.):_____

_____

_____

16. Child's Strengths & weaknesses in learning ability:_____

_____

17. Activities (hobbies, interests, organized groups, sports, etc.):_____

_____

18. 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 below:_____

_____

19. Please describe any involvement your child/teen has had with the legal system (arrests, tickets, truancy, etc.):_____

_____

20. Has your child/teen received prior counseling or related services? ☐ Yes ☐ No

If yes, please provide the name of the therapist(s) seen, clinic name, date range of services, reason & outcome:

_____

_____

Client Name:_____ **DOB:**_____

If child/teen has requested therapy, please allow him/her to answer questions 21-24, helping if needed.

21. Why did you want to come to counseling?_____

22. What questions do you hope will be answered? _____

23. Is there any additional information you'd like the therapist to know before your first appointment? _____

24. Do you have any concerns about alcohol or other substances?_____

Parent should complete questions 25-27 & Goals section.

25. What are your major concerns at this time?_____

26. What questions do you hope will be answered? _____

27. Is there anything else you want the therapist or counselor to know before the first session? _____

GOALS

1. What are your child/teen's strengths? _____
2. What are your child/teen's weaknesses? _____
3. What goals would you like to see reached as a result of his/her involvement in treatment?_____
4. How will you know when these goals have been reached?_____

Child/Teen Signature:_____ **Date:**_____
(required if 14 or older)
Parent/Guardian Signature: _____ **Relationship:** _____
(required if under 18)

THERAPIST REVIEW

Signature: _____ Date: _____