Willow Creek Counseling Center, LLC **859-554-0740** **1050 Chinoe Rd. Suite 203 Lexington, KY 40502**

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

Please use the backs of the pages for additional details.

GENERAL INFORMATION:

Today's Date:_____ Person Completing Form:_____ Child's Name:_____ Date of Birth:_____Age:__ Home Address:_____

1. Parent's Name: _____ DOB: _____
Address (City, State and Zip):_____
Marital Status:_____ Male/Female: _____
Phone: H(____)_____W(____)_____C(____)_____ OK to say TPFCC? Yes _____ No_____
Emergency contact (name and phone #)_____

2.Parent's Name: _____ DOB: _____
Address (City, State and Zip):_____
_____
Marital Status:_____ Gender: _____ Phone: H(____)_____W(____)_____C(____)_____ Do we have your permission to leave messages? Yes _____ No_____ Emergency contact (name and phone #)_____

3. Step Parent(s)/Guardian(s):_____DOB: _____
Address (City, State and Zip):_____
_____ Marital Status:_____ Gender: _____ Phone:

H(____)_____W(____)_____C(____)_____ Do we have your permission to leave messages? Yes _____ No_____ Emergency contact (name and phone #)_____

History of Problem Please describe what concerns you have regarding your child:

_____
_____
_____
_____
_____
_____

How long has the problem existed?

_____
_____
_____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

_____
_____
_____
_____

What attempts have been made to resolve the difficulties?

_____
_____
_____
_____

What are you hoping to gain from seeing a counselor?

_____
_____
_____
_____

Please select the symptoms that the child is currently experiencing.

		Severity of symptoms None Mild Moderate Severe
Symptom	Yes/No	How long? 0,1,2,3

sadness or depression			
suicidal thoughts			
sleep problems			
changes in appetite			
weight change			
inability to focus			
obsessive thoughts			
tension and anxiety			
panic attacks			

memory problems			
compulsive behaviors			
feelings of hostility			
acts of violence			
social isolation			
strange thoughts			
stomach aches			

headaches			
bed wetting			
phobias			
self harm			

Any other symptom not listed? _____

Parent Information

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc)?

_____
_____
_____
_____

For Parents who are divorced, please state custody arrangements. (If so, we will need a copy of the custody agreement in the file)

_____
_____
_____

Is the ex-spouse (biological parent) aware that you are bringing their children for therapy? ❑

Yes

❑ No

If not, please explain.

_____
_____

Mother's Name: _____ Age: _____
Occupation:_____ Employment status: _____
Employer's name and address:_____
_____
Significant medical problems:_____
_____
Serious illnesses, accidents, or surgeries in the
past:_____
_____

Current and past psychiatric treatment or counseling:_____
_____
Currently prescribed medications:_____
_____
Current alcohol/drug use (amount, how often, intoxication frequency):_____
_____
History of alcohol/drug use?_____
_____
History of arrest?_____
_____
Primary Care Physician:_____
Psychiatrist:_____
Father's Name:_____ Age: _____
Occupation: _____ Employment status: _____
Employer's name and address: _____
Significant medical problems:_____
Serious illnesses, accidents, or surgeries in the past:_____
Current and past psychiatric treatment or counseling:_____
Currently prescribed medications:_____
Current alcohol/drug use (amount, how often, intoxication frequency):_____
_____
History of alcohol/drug use?_____
History of arrest?_____
Primary Care Physician:_____
Psychiatrist:_____

Step-parent/Guardian:_____ Age: _____ Occupation: _____ Employment status: _____ Employer's name and address: _____ Significant medical problems:_____ Serious illnesses, accidents, or surgeries in the past:_____ Current and past psychiatric treatment or counseling:_____ Currently prescribed medications:_____ Current alcohol/drug use (amount, how often, intoxication frequency)_____ History of alcohol/drug use?_____ History of arrest?_____ Primary Care Physician:_____
Psychiatrist:_____

Child Information:

1). Name of Child:_____ Age:_____
Child lives with:_____ School:_____
Grade:_____ Teacher: _____

If adopted, does the child know of adoption?

❑ Yes

❑ No

What age was your child at the time of the adoption?_____

History of psychiatric treatment or counseling:_____
_____

Does child have a mental health diagnosis?_____
_____

Current or past drug or alcohol use (indicate past or present amount, frequency)_____
_____

Significant medical problems:_____
_____

Does child have a learning or physical challenge? (If yes, please specify)_____
_____

Serious illnesses, accidents, or surgeries in the past:_____

Medications currently prescribed:_____

Pediatrician:_____

Psychiatrist:_____

Trauma history:

Has the child been verbally abused? Y__ N__ Suspected__ Specify:_____
_____ Has the child been physically abused? Y__ N__ Suspected__ Specify:_____
_____ Has the child been sexually abused? Y__ N__ Suspected__ Specify:_____
_____ Has the child witnessed domestic violence? Y__ N__ Suspected__ Specify:_____
_____

Other stressors or traumas?_____
_____
_____

********** How did you hear about us?_____