Logstrom Counseling, LLC

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: _____
Street

_____
City State Zip

Home Phone: _____

Work Phone: Mother:_____ Father: _____

Cell Phone: Mother:_____ Father: _____

E-Mail: Mother:_____ Father: _____

School:_____ System:_____ Grade: _____

School's telephone number: _____

Teacher(s): _____

Who referred you to our office? _____

Please sign below if you give permission for us to thank this person:

_____

REASON FOR REFERRAL / CURRENT SYMPTOMS

Please describe the problems your child is now having and the type of services you are seeking.

_____

_____

_____

_____

_____

_____

_____

Please indicate if your child is experiencing any of the following difficulties:

_____ School attention/concentration problems
_____ Grades dropping or consistently low
_____ Hyperactive, difficulty being still
_____ Impulsive, doesn't think before acting
_____ Sadness or Depression
_____ Generalized Anxiety (across many situations)
_____ Specific fears/phobias (list): _____
_____ Social Anxiety
_____ Obsessive-Compulsive / Rigid behavior patterns
_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
_____ Isolated socially from peers
_____ Problems making or keeping friends
_____ Problems with eating
_____ Problems falling asleep
_____ Problems sleeping through the night (middle of the night or early morning waking)
_____ Trouble waking up
_____ Fatigue/tiredness during the day
_____ Nightmares
_____ Noncompliant, purposely does not obey (not due to language or cognitive deficits)
_____ Oppositional, defiant behavior
_____ Problems controlling temper
_____ Tantrums / "Meltdowns"
_____ Problems with authority (breaking rules or laws)

_____ Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)

_____ Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)

_____ Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)

_____ Wetting accidents (indicate day or night wetting): _____

_____ Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)

_____ History of abuse (emotional, physical, sexual)

_____ Alcohol or drug use/abuse

_____ Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

_____ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

_____ Stress from conflict between parents

_____ Stress due to family financial problems

_____ Legal situation (anyone in family)

Other behavior problems: _____

PARENTS / GUARDIANS AND FAMILY INFORMATION:

Mother's Name:_____ Age: _____

Occupation:_____ Education Completed: _____

Health: _____Excellent _____Good _____Fair _____Poor

Father's Name:_____ Age: _____

Occupation:_____ Education Completed: _____

Health: _____Excellent _____Good _____Fair _____Poor

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

If married, how long have you been married? _____

If divorced, how long have you been divorced? _____

If divorced, who has physical custody?_____ Is it full or joint? _____

Who has legal custody?_____ Is it full or joint? _____

Please provide a copy of the custody agreement.

Has either parent been married before or since? Mother:_____ Father: _____

If yes, provide dates of other marriage(s), names, and ages of children from these marriages:

Mother:_____ Children and ages: _____

Father:_____ Children and ages: _____

Is there a birth parent living outside the home: (circle one) MOTHER FATHER

Where does this parent live? _____

If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody, with stepsiblings, etc.?

_____

_____

How would you rate the quality of your present marriage?

Mother:_____Great_____Very Good _____Good _____Fair _____Poor _____Very Poor

Father:_____Great_____Very Good _____Good _____Fair _____Poor _____Very Poor

Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain:

_____

_____

Who supervises the child's care when not in school? _____

_____

_____

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

Sibling Name	Age	School	Grade Placement	Grade Average	Conduct*

*(Please indicate good, fair, or poor conduct)

In general, how would you say the child for whom you are seeking services gets along with these siblings?

_____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Describe: _____

_____

_____

Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.).

Name	Age	Relationship to Child	Years Living in Home
_____	_____	_____	From_____to _____
_____	_____	_____	From_____to _____
_____	_____	_____	From_____to _____
_____	_____	_____	From_____to _____

Are there other relatives who have a significant impact on how this child is raised?

_____

FAMILY STRESS LEVEL

Please rate the overall level of FAMILY stress:

_____Very Low _____Low _____Average _____High _____Very High

What is the greatest source of stress for the family at this time?

_____

Please rate the overall level of stress in the mother's life:

_____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in the mother's life?

_____

Please rate the overall level of stress in the father's life:

_____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in the father's life?

_____

How would you rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Mother: _____ Father: _____

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who.

Yes	Condition	Family Member
_____	General Developmental Delays or Cognitive Delay	_____
_____	Speech or Communication Disorder	_____
_____	Intellectual Disability (mental retardation)	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Learning Problems / Disabilities	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Sleep disorders	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Social Anxiety	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Depression	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Schizophrenia or other psychosis	_____
_____	Alcohol / Substance Abuse	_____
_____	Seizures or other neurological disorder	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____
_____	Other: _____	
	_____	

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

_____

_____

_____

_____

_____

_____

DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.

_____

_____

_____

_____

_____

Child was born: _____premature _____at full term _____late

Birth Weight_____lbs,_____oz

Difficulties following delivery? _____

_____

Nursery (check all that apply): _____Well-baby _____Transitional ____Intensive Care _____Other

Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.)

_____

Any medical problems diagnosed in infancy? _____

_____

_____

As an infant, did this child seem:

_____less active than average _____average _____overly active

As a toddler, did this child seem:

_____less active than average _____average _____overly active

As a preschooler, did this child seem:

_____less active than average _____average _____overly active

As the child entered school, did this child seem:

_____less active than average _____average _____overly active

At what age did your child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet."

	Early	On-Time	Late	Approximate age (if known)
Speech and Language				
Coo/babble				
Respond to name				
Say first word				
Use gestures (wave, point)				
Put words together				
Speak in sentences				
Follow simple directions				
Follow multistep directions				
Motor Skills				
Roll over				
Sit alone				
Stand alone				
Walk alone				
Hold pencil correctly to mark				
Write legibly				
Self-Help/Independence				
Feed self				
Toilet train (bladder)				
Toilet train (bowel)				
Dress self				
Bathe self				
Social/Emotional				
Smile at others				
Laugh aloud				
Show affection				
Engage in pretend play				
First friendship				
Control feelings when upset				
Understand others' feelings				
Show responsibility				

MEDICAL HISTORY

Name of Child's Primary Physician: _____

Physician's Address: _____

_____

Physician's Phone: _____

List any other physicians or health professionals your child sees for services on a regular basis.

_____

_____

_____

When was your child last seen by a physician?

_____

Rate your child's overall health

_____Excellent _____Good _____Fair _____Poor

Child's current height:_____ft,_____in. Weight:_____lbs.

Does your child have any vision problems? _____

Date of last vision test and who performed (physician, optometrist, school) _____

Does your child have any hearing problems? _____

Date of last hearing test and who performed (physician, audiologist, school) _____

Is your child: _____right handed _____left handed _____does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.

_____

_____

_____

_____

_____

_____

List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time. Use back of page if needed.

_____

_____

_____

Describe your child's regular diet (i.e, favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating)?

_____

_____

_____

What is your child's typical bedtime and wake time each day? Any concerns about your child's sleeping habits?

_____

_____

_____

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?

_____

_____

_____

EDUCATIONAL AND SOCIAL HISTORY

List in chronological order all schools your child has attended:

	Name of School	Dates Attended	Grade Placement	Grade Average	Behavioral Conduct
1.	_____	From_____To_____	_____	_____	_____
2.	_____	From_____To_____	_____	_____	_____
3.	_____	From_____To_____	_____	_____	_____
4.	_____	From_____To_____	_____	_____	_____
5.	_____	From_____To_____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)

Name of current teacher (s): _____

What concerns does your child's teacher have about him/her?

_____

_____

What is your child's favorite subject? _____

What is your child's least favorite subject? _____

Has your child ever repeated a grade?_____ If so, which? _____

Has your child ever skipped a grade?_____ If so, which? _____

Has your child ever had tutoring?_____ Which subjects? _____

When and with whom? _____

Has this child ever been in a Special Education Program?_____ If so, during what years? _____

How much of the school day? _____

What type of program? (LD, Gifted, EBD, ASD, etc.): _____

Child's attitude toward school: _____

How does your child interact with peers and adults in social situations? Do you have concerns about your child's social skills or development?

_____

_____

_____

_____

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

_____Sports (list): _____

_____Music (list): _____

_____Clubs/Groups (list): _____

_____Dance (list): _____

_____Other: _____

Describe your child's strengths, positive qualities, and any special abilities or skills.

_____

_____

_____

BEHAVIOR MANAGEMENT / DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed: (circle the appropriate number)

	Very Unlikely				Very Likely
Let situation go	1	2	3	4	5
Time out	1	2	3	4	5
Send to room	1	2	3	4	5
Take away a privilege (ex., no TV)	1	2	3	4	5
Take away something material (ex., no dessert)	1	2	3	4	5
Assign an additional chore	1	2	3	4	5
Ground child	1	2	3	4	5
Reason with child / Problem-Solve / Negotiate	1	2	3	4	5
Yell at child	1	2	3	4	5
Physical punishment	1	2	3	4	5
List anything else you may do:					
	1	2	3	4	5
	1	2	3	4	5

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Then, please circle the strategy that is LEAST effective.

Please rate what percentage of discipline is handled by each of the following:

Father:_____% Mother:_____% Other:_____% (Please specify):_____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

	Would like Child to do More Often	Would like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain

_____

_____

_____

Is there anything else we should know about your child that was not covered by this form?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date: _____