



ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

Toll Free: 800-681-2374

Mailing Address: PO Box 959, Stevens Point, WI 54481

Fax: 715-952-4995

Email: office@advocatepsychotherapyservices.com

Website: www.advocatepsychotherapyservices.com

INTAKE QUESTIONNAIRE – CHILD

Name of Person Completing this Form: _____

Relationship to Child: _____ Who referred you: _____

Home Phone: _____ Work Phone (indicate whose #) _____

If you feel 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: _____

IDENTIFYING INFORMATION (For individual receiving services)

Child's Name: _____ Date of Birth: _____

Address: _____ Sex: _____ Age: _____

Home Phone: _____ Work Phone (indicate whose #): _____

PRESENTING PROBLEM (Current Situation and History)

What is the primary problem for which you are seeking help? (Please circle)

- | | | |
|---------------------|-----------------------|----------------------------|
| a. Behavior at Home | e. Behavior at School | i. Eating Disorder |
| b. Family Problems | f. Self-Confidence | j. Alcohol/Drug Use |
| c. Depression | g. Overactivity | k. Physical |
| d. Mood Swings | h. Peer Problems | l. Other: (Please Explain) |

How long has the child had this problem(s): _____

Has the child received treatment for this problem? Yes _____ No _____ If "yes", when, where, and with whom? _____

HOME BEHAVIOR

1. Is there a behavior problem at home? Yes _____ No _____ If "yes" please

explain _____

2. What kind of discipline is used with the child? _____

3. Who is the primary disciplinarian? _____

HOUSEHOLD FAMILY MEMBERS				
Name	Age	Relationship	Lives with You	If "no" lives where?
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
MEDICATIONS				
MEDICATION	DOSAGE/ FREQ.	PRESCRIBING PHYSICIAN	FOR WHAT CONDITION	

SCHOOL INFORMATION

What school does the child currently attend? _____

What grade is the child in? _____ Is the child in special education classes? Yes _____ No _____

Is the child experiencing any problems in school?

Academics (grades): Yes _____ No _____ Social (peers or adults) Yes _____ No _____

Behavior Yes _____ No _____

Please explain any "yes" responses: _____

Anything else you want your therapist to know right away?



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Parent/Guardian Signature: _____ Date: _____