ADVOCATE PSYCHOTHERAPY SERVICES

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

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INTAKE QUESTIONNAIRE – CHILD

Name of Person Completing this Form:_____

Relationship to Child:_____ Who referred you:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ *(circle preferred #)*

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:_____ DOB:_____ Age:_____ Sex:_____ Race: _____

Home Address:_____ City:_____ State: _____ Zip Code:_____

Household Members:

Name	Age	Relationship	Lives with you?	If "no" lives where?
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	

Medication(s):

Medication Name	Dosage/Time	Reason	Prescribing Physician	Currently Taking

Past Behavioral Healthcare Services/Hospitalizations:

Name of Therapist/Agency	Date of Services	Reason for Services

(OVER)

PRESENTING PROBLEM (Current Situation and History)

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

a. Home or School Behavior
b. Family Problems
c. Depression
d. Mood swings
e. Social or Public Behavior
f. Self-Confidence
g. Excessive Energy
h. Peer Problems
i. Eating Disorder
j. Alcohol/Drug Use
k. Physical
l. Other: _____

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?_____

SCHOOL INFORMATION

What school does the child currently attend? _____What grade is the child in? _____

Does your child have an IEP? Yes____ No _____ Does your child have a diagnosed disability? Yes_____ No_____

Please explain disability: _____

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:_____

_____

What are your child's hobbies or things they enjoy in their life?

_____

_____

What are your goals for your child?

_____

_____

Anything else you want your child's therapist to know right away?

_____

_____

Parent/Guardian Signature: _____ Date: _____