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Child's Name: _____ DOB: _____ AGE: _____ Today's Date: _____

Your Name: _____ Relationship to Child: _____

1. What is your major concern that led you to seek help?

2. Please briefly describe other concerns you might have? (Other common areas of concern will be inquired later).

3. Is there a particular reason you are seeking an appointment *now*?

4. Has the child ever been assessed or received counseling before? Yes _____ No _____

Describe when, with whom, and what happened. **Please provide copies of any private or school assessment reports.**

BIRTH HISTORY/EARLY CHILDHOOD

5. Was the child adopted? No _____ Yes _____ If yes, at what age? _____

6. Were there any problems or unusual circumstances during the pregnancy, labor, or delivery? Premature baby?

No _____ Yes _____ Don't know _____ Please describe if "yes".

7. Did the bio-mother use drugs, alcohol, medication, or smoke cigarettes during pregnancy? If so, describe what and to what extent.

8. As an infant, was the child difficult, demanding, hard to soothe, have colic or feeding/sleeping problems?

No _____ Yes _____ Don't know _____ If yes, please describe.

9. Were there any other health problems during infancy? Please describe.

10. Have there been any developmental problems in learning to crawl, walk, talk, toileting, or other?

No _____ Yes _____ Don't know _____ If yes, please describe.

MEDICAL/HEALTH HISTORY

11. Has the child been to the doctor in the last year? No _____ Yes _____

12. How is the child's current health? Is the child being treated for anything?

13. Describe history of any medical problems.

	<u>Age of onset</u>	<u>Type of problem</u>	<u>Duration of problem or age problem ended</u>
Allergies or food sensitivities	_____	_____	_____
Ear infections, frequent colds	_____	_____	_____
Serious or chronic illnesses	_____	_____	_____
Visual difficulties	_____	_____	_____
Hearing/Speech disorders	_____	_____	_____
High fevers	_____	_____	_____
Drug overdose/poisoning	_____	_____	_____
Migraines/ headaches	_____	_____	_____
Seizures	_____	_____	_____
Motor coordination problems	_____	_____	_____
Accidents/Injuries	_____	_____	_____
Head injury or concussion	_____	_____	_____

Please elaborate on anything noted above. Please describe head injuries in detail, even if ruled out as non-serious earlier.

14. Does the child complain of pain or headaches? No _____ Yes _____

If yes, please describe the type, frequency and severity?

15. Has the child been hospitalized? No _____ Yes _____ If yes, when and for what problem?

16. Is the child currently taking medication, either prescription or over-the-counter? No _____ Yes _____

If yes, carefully list the specific medication and dose date first prescribed, who prescribed and for what condition

#1 _____

#2 _____

17. Has the child ever taken medication for attention, behavior, or mood problems in the past? No _____ Yes _____
If yes, list the specific medication and dose, dates taken, who prescribed, for what condition, effectiveness, side effects
#1 _____
#2 _____
#3 _____

18. Is the child allergic to any medications? No _____ Yes _____ If yes, please describe.

19. Please circle any of the following sleep problems that your child has:

- | | |
|-------------------------------|---------------------------|
| Difficulty waking in morning | Difficulty falling asleep |
| Not rested after sleep | physically restless sleep |
| Frequent waking during night | Nightmares (bad dreams) |
| Sleeping too much | Teeth grinding |
| Snoring | restless leg |
| Sleep Apnea (stops breathing) | |

20. Does the child have current problems with eating (overeating, undereating, binge/purge, non-food eating)? Please describe if yes.

21. Does the child have current problems with toileting, bedwetting, constipation, accidents? Please describe if yes.

22. Please list and describe any known or suspected use either past or present of tobacco, alcohol, or recreational drugs. Any treatment?

23. Does the child drink coffee or other caffeinated beverages? Please describe amount.

FAMILY/SOCIAL HISTORY:

24. Please identify each parents' job, highest school grade achieved?

25. Please list who *lives in the child home*, ages of sibs, and describe the nature of the child's relationship with all in-home family members.

26. Please list any and all separations or divorces of child's parents. Age of child at these times? Child's adjustment to the changes?

27. Please list any parents/siblings *living out of the child's home*: non-custodial parent, step-parent, half/step siblings, and the nature of the child's relationship with them.

28. Has the child experienced any other family crises: multiple moves/school changes, serious parental conflict, dramatic financial change, parental mental health/substance abuse problems, etc. If yes, please describe.

29. For each of the following, please identify any blood relatives (children, siblings, parents, grandparents, cousins, aunts or uncles) who may have had problems in these areas (i.e. "mom's sister Jennifer", "dad's brother Mike").

Problems with attention including being distractible, hyperactive or impulsive.

Problems in school, learning to read, write, or do math.

Problems with anger or violence

Headaches/migraines/
seizures/neurological problems

Depression, Anxiety
Other mental health problems

Alcohol or drug abuse

30. Has the child been affected by any issues, such as witnessing violence, traumatic accident, loss, experiencing abuse (physical, sexual, emotional)? No ___ Yes ___ Please describe the relevant issue.

PEER RELATIONSHIPS/CHILD'S TEMPERAMENT:

31. Please describe the nature of the child's peer relationships: ability to make/get along with/hold on to friends.

32. In relating to others, what problems, if any, does your child have in terms of lacking empathy, being manipulative or failing to show remorse when appropriate?

33. Does your child have problems either understanding or expressing emotions? Does your child have problems with social awareness? Please describe.

34. Have there been any recent changes in the child's interests, mood, energy level, or activities? If yes, please describe.

Any known cause of change?

35. What problems, if any does the child have with irritability and anger? When angry, is the child more likely to let the anger go quickly or hold onto resentment?

36. Has the child ever become violent or destructive? Has the child ever hurt someone intentionally or threatened to harm or kill someone? What interest does the child have in weapons?

37. What problems, if any does the child have with authority or with getting into trouble, unlawful activity or actions that could cause legal consequences?

38. What problems, if any, does the child have with fears, tension, anxiety, panic attacks, phobias, being uncomfortable in new situations or shyness? How has that changed over time?

39. What problems, if any does your child have with their feeling too easily hurt? Are there any indications that the child has problems with self-esteem? Are there particular things your child is most likely to feel bad about?

40. What problems, if any, does the child have with sadness, irritability, frequent guilt or shame, rarely feeling happy or enjoying things, crying easily, or other signs of depression?

41. Has the child ever talked about wishing they were dead or discussed or attempted suicide? Please describe.

42. Please describe any ideas, fears or concerns about which the child obsesses or worries?

43. Please describe any of the child's habits, rituals or other compulsive behaviors?

44. What problems, if any, does the child have with muscle or verbal tics? These are repetitive movements or noises such as eye-blinking, facial twitching, or noises such as grunting, snorting, barking, squeaking, or humming.

45. (Adolescent females only) what problems, if any does the child have with unusual depression, irritability or discomfort during the week or so before the menstrual period?

SCHOOL HISTORY:

46. What is the child's current grade and what school does he or she attend?

47. When did the child start school and were there any problems when school started?

48. Please mark with an "X" which, if any, of the following have occurred and during what period in the child's schooling.

	Elementary School	Middle School	High School
Reading difficulties	_____	_____	_____
Math difficulties	_____	_____	_____
Writing difficulties	_____	_____	_____
Poor grades	_____	_____	_____
Homework problems	_____	_____	_____
Behavior problems	_____	_____	_____
Peer Problems	_____	_____	_____
Disliked/avoided school	_____	_____	_____

49. Please circle any of the following that are problems:

Dyslexia (difficulty learning to read, blend sounds, read smoothly)

Poor tracking while reading (losing place in line, missing words)

Poor reading comprehension or recall

Poor arithmetic calculations

Poor sequential processing (doing things in order, one step after the next

Poor spelling

Inability to write neatly (even slowly)

Poor math concepts

Poor visual-spatial skills (drawing, copying figures)

Poor sense of direction

Poor balance or coordination

50. Please describe child's greatest strengths and any special abilities or talents. What school subjects have he or she generally done best in? What are the child's current grades?

51. What problems, if any does the child have with daydreaming, staying on-task or being disorganized? At what age did you first notice this?

52. What problems, if any does the child have with hyperactivity, stimulus seeking or feeling restless? At what age did you first notice this?

53. What problems, if any does the child have with impulsivity, impatience or acting without thinking of consequences? At what age did you first notice this?

54. If the parent asked the child to do 10 things over the span of a day, how many would the child do correctly on the first request, without arguing or delaying? _____

55. PLEASE LIST ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ON THE BACK OF THIS PAGE:

Name _____ Child Intake Questionnaire -10- Please turn to next page