

**Melissa Tolman  
Psychotherapy Services**

**Child /Adolescent Intake Form and History Questionnaire**  
(To be completed by parents/guardian)

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Child's name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_

Main Contact Phone Number: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parents Marital Status: \_\_\_\_\_

Pediatrician/Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Emergency Contact/Phone : \_\_\_\_\_

**Current Family Structure:** (residing in the home)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Job/School</u>	<u>Mental Health History</u>	<u>Relationship with Child</u> (positive, conflicted, etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Other Children:** (not in home)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Job/School</u>	<u>Mental Health History</u>	<u>Relationship with Child</u> (positive, conflicted, etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Current Concerns (Please describe briefly) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Client Name: \_\_\_\_\_

**Prenatal History:**

1. Prenatal care: \_\_\_\_\_
2. Mother's health during pregnancy: \_\_\_\_\_
3. Implications, abnormal test results or medical concerns during pregnancy: \_\_\_\_\_
4. Fetal exposure to alcohol, cigarettes, or drug use during pregnancy: \_\_\_\_\_
5. Infant's health/weight at birth: \_\_\_\_\_
6. Unusual aspects to the delivery (e.g. prematurity, lack of oxygen...) \_\_\_\_\_

**Early Development:**

7. List ages your child reached the following developmental milestones:

Sitting\_\_\_\_                      Crawling\_\_\_\_                      Walking\_\_\_\_  
Using Single Words\_\_\_\_ Using sentences\_\_\_\_                      Toilet Trained\_\_\_\_

8. My child's temperament as an infant and toddler were: (check as many as apply)

Easy                       Cautious                       Excitable   
Fussy                       Slow to warm up                       Colicky   
High Energy                       Shy                       Alert

9. History of articulation problems or regression in language skills: \_\_\_\_\_
10. History of motor problems or regression in motor skills: \_\_\_\_\_
11. History of social problems or regression in social-relatedness skills: \_\_\_\_\_

**Family History:**

12. Child's primary caretaker(s) throughout childhood: \_\_\_\_\_
13. Significant family stressors or changes in your child's lifetime (e.g. death, divorce, traumatic event) \_\_\_\_\_  
\_\_\_\_\_

**Medical History:**

14. Medical or mental health conditions: \_\_\_\_\_
15. Previous hospitalizations and dates: \_\_\_\_\_
16. Current Medications: 

<u>Medication</u>	<u>Dose</u>	<u>Treating Physician</u>

Client Name: \_\_\_\_\_

17. History of Psychotherapy: Previous Therapist      Dates      Issues Addressed

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18. Hearing and/or vision problems: \_\_\_\_\_

**School/Job:**

19. Typical grades earned by your child, including any significant or recent changes in grades:

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20. History of learning disability or concerns: \_\_\_\_\_

21. Repeated any grades: \_\_\_\_\_

22. Child's style of interacting with teachers: \_\_\_\_\_

23. Child's style of interacting with peers: \_\_\_\_\_

24. Behavioral concerns at school: \_\_\_\_\_

25. Extracurricular activities: \_\_\_\_\_

**For parents/guardians of teenagers:**

26. Your goals for your teenager after graduation from high school: \_\_\_\_\_

27. Your teenager's job history: \_\_\_\_\_

Client Name: \_\_\_\_\_

**Child's Personal Characteristics:**

28. Strengths: \_\_\_\_\_

29. Weaknesses: \_\_\_\_\_

30. Hobbies/Interests: \_\_\_\_\_

31. Child's usual mood: \_\_\_\_\_

32. Child's relationship with neighborhood friends: \_\_\_\_\_

33. Types of discipline that are effective with your child: \_\_\_\_\_

Current Symptoms: Please check all that apply:

- Irritability
- Aggression
- High activity level
- Staring spells
- Trouble expressing him/herself
- Frequent fatigue
- Low energy level
- Trouble falling asleep
- Trouble getting up in the morning
- Frequent awakenings
- Easily frustrated

- Recent weight gain/loss
- Appetite changes
- Excessive fears/worries
- Social isolation
- Depressed mood
- Mood swings
- Hopelessness
- Anxiety
- Anger/rage
- Guilt
- Grief/mourning
- Coping with pain

- Sexual abuse history
- Physical abuse history
- Suicidal thoughts/actions
- Desire to hurt someone
- Drug/alcohol use
- Tobacco use
- Self-harm
- Problems in thinking
- Problems with memory