BENCHMARK PARENTING

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Demographics

Name: _____ Date: _____

Gender: _____ Date of Birth: _____ Age: _____

Ethnicity: _____ Religious Identity: _____ Sexual Orientation: _____

Full Address: _____

Child/Adolescent cell phone (if applicable): _____

Child/Adolescent email (if applicable): _____

Referred by: ☐ Medical/Mental Health Professional (specify): _____

☐ Website (specify): _____

☐ Other (specify): _____

Parent/Guardian Name: _____

Gender: _____ Age: _____ Education Level: _____

Full Address: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Preferred Contact? _____

Occupation: _____

Parent/Guardian Name: _____

Gender: _____ Age: _____ Education Level: _____

Full Address: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Preferred Contact? _____

Occupation: _____

Presenting Problem

What are the main symptoms you are seeking treatment for? _____

_____

_____

_____

_____

How long have these symptoms been going on? _____

What have you tried in the past to cope with these symptoms? Was it helpful? _____

_____

_____

_____

Have you experienced any significant life changes or stressful events recently? Please describe:

_____

_____

_____

Why have you chosen to seek treatment at this time? _____

_____

_____

_____

Current Medications

Name:	**Dose(mg)/day:**	**Prescribed for:**	**Prescribed by:**

Current Psychiatrist Name: _____

Address: _____

Phone: _____ Fax: _____

Treatment History

Child/Adolescent prior counseling or psychiatric treatment

Doctor/Therapist Name	Clinic/Institution	Dates	Reason	Was treatment effective?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Family Medical/Psychiatric History

Please note whether each relative has any of the conditions or problems noted below.

Condition	Mother	Father	Siblings	Maternal side	Paternal side
Anxiety					
Depression/Bipolar					
Alcohol/Drug Abuse					
Psychosis/Schizophrenia					
Attention/Behavior Problems					
Learning disabilities/problems					
Health Problems					

Provide explanation for any items checked above: _____

Family Background

Please list all immediate members of your child's family, relationship to your child (mother, father, stepfather, half-sister, adopted brother, etc.), and briefly describe how well your child gets along with this person (e.g., distant, close, dependent, constantly arguing, protective, etc.)

Name	Age	Relationship	In the home?	How well does your child get along with this person
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never married

If parents are separated or divorced, indicate the date of separation and describe the current custody and visitation arrangement:

_____

_____

What is the primary language spoken in the home? _____

Does the family speak a second language? ☐ No ☐ Yes Language: _____

Who supervises your child when the parents are out of the home? (check all that apply)

☐ Daycare Center ☐ Relative ☐ Private Sitter ☐ Child stays by himself/herself

☐ Other: _____

Who primarily disciplines your child? _____

Which disciplinary methods are used? (check all that apply and circle methods that seem most effective)

☐ Explaining the problem ☐ Spanking or other physical punishment ☐ Rewards/Allowance

☐ Verbal reprimands (scolding) ☐ Taking away privileges/grounding ☐ Time-outs

☐ Avoiding contact with child ☐ Other: _____

What percentage of time does your child do what s/he is told?

At home: _____ At school: _____ Other: _____

What chores/responsibilities does your child have at home? (Please describe)

_____

_____

_____

How compliant is your child/adolescent with these chores? _____

Does your child/adolescent receive an allowance? ☐ No ☐ Yes

If yes, are there tasks/responsibilities associated with the allowance?

_____

_____

Developmental History

Length of Pregnancy: _____ Mother's age when child was born: _____

Length of delivery (# of hours): _____ Child's birth weight: _____

Were there any complications with pregnancy? ☐ No ☐ Yes ☐ Unknown

Explain: _____

_____

Were there any complications with delivery for your child? ☐ No ☐ Yes ☐ Unknown

Explain: _____

_____

During the first 12 months, was your child:

Difficult to feed	☐ No	☐ Yes	Difficult to get to sleep	☐ No	☐ Yes
Colicky	☐ No	☐ Yes	Difficult to put on a schedule	☐ No	☐ Yes
Alert	☐ No	☐ Yes	Cheerful	☐ No	☐ Yes
Affectionate	☐ No	☐ Yes	Sociable	☐ No	☐ Yes
Easy to comfort	☐ No	☐ Yes	Difficult to keep busy	☐ No	☐ Yes
Overactive, in constant motion	☐ No	☐ Yes	Very stubborn, challenging	☐ No	☐ Yes

Did your child accomplish the following on time?

	Early	On Time	Late
Sit without help	☐	☐	☐
Crawling	☐	☐	☐

Walk alone	☐	☐	☐
Use single words	☐	☐	☐
Put 2-3 words together	☐	☐	☐
Spoke in sentences	☐	☐	☐
Toilet trained (day and night)	☐	☐	☐

Did your child receive Early Intervention or Specialized Preschool Programming? ☐ No ☐ Yes

If yes, explain: _____

_____

_____

Medical History

Primary Care Physician/Pediatrician: _____

Address: _____ Phone: _____

Current height: _____ Current weight: _____

Current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Check any current or past medical concerns:

Asthma	☐ Never	☐ Past	☐ Present	Cancer	☐ Never	☐ Past	☐ Present
Allergies	☐ Never	☐ Past	☐ Present	Thyroid problems	☐ Never	☐ Past	☐ Present
Anemia	☐ Never	☐ Past	☐ Present	Broken bones	☐ Never	☐ Past	☐ Present
Diabetes	☐ Never	☐ Past	☐ Present	Strep throat	☐ Never	☐ Past	☐ Present
Hearing problems	☐ Never	☐ Past	☐ Present	Sensory issues	☐ Never	☐ Past	☐ Present
Vision problems	☐ Never	☐ Past	☐ Present	Frequent headaches	☐ Never	☐ Past	☐ Present
High fevers	☐ Never	☐ Past	☐ Present	Stomachaches	☐ Never	☐ Past	☐ Present
Heart disease	☐ Never	☐ Past	☐ Present	Seizures/epilepsy	☐ Never	☐ Past	☐ Present
Frequent ear infections	☐ Never	☐ Past	☐ Present	Head injury/loss of consciousness	☐ Never	☐ Past	☐ Present
Soiling problems	☐ Never	☐ Past	☐ Present	Urination problems	☐ Never	☐ Past	☐ Present
Gross motor problems	☐ Never	☐ Past	☐ Present	Fine motor problems	☐ Never	☐ Past	☐ Present
Speech/language problems	☐ Never	☐ Past	☐ Present	Dizziness/blurred vision	☐ Never	☐ Past	☐ Present
Other Illnesses:	☐ Never	☐ Past	☐ Present	Other Illnesses:	☐ Never	☐ Past	☐ Present

How would you describe your child/adolescent's current sleep habits?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Typical weekday bedtime? Wake up time? _____

Typical weekend bedtime? Wake up time? _____

How long does it take for child to fall asleep? _____

Frequency of nighttime awakenings and for how long? _____

Do they take naps? How long? How often? _____

What activities does child engage in 1-2 hours before bedtime? _____

_____

Please list any specific problems with sleep they are experiencing: _____

_____

_____

Social History

What social activities, hobbies, and/or sports does your child enjoy? _____

_____

_____

_____

How many hours in a week do they spend in these social activities? _____

Please describe the child's strengths: _____

_____

_____

Substance Use History

Do you know or suspect that your child is using or experimenting with drugs (e.g., cannabis, opiates, cocaine, prescription pills, inhalants, hallucinogens) or alcohol?

☐ No ☐ Yes, describe: _____

_____

_____

_____

_____

School History

School Name/Address: _____

_____

_____

School Counselor/Teacher: _____ Email/Phone: _____

_____

_____

Current Grade: _____ Typical Grades: _____

Average amount of time spent on homework nightly: _____

Who helps with homework, if help is needed? _____

Has your child ever repeated or skipped a grade? ☐ No ☐ Yes, indicate grade(s) and reason:

_____

_____

Has your received academic or psychological testing? ☐ No ☐ Yes, describe:

_____

_____

Does your child have an IEP or 504? ☐ No ☐ Yes, describe: _____

_____

_____

Which of the following best describes your child's school behavior and attitude? (check all that apply)

☐ Happy	☐ Fearful	☐ Argues with teachers	☐ In gifted program
☐ Well-adjusted	☐ Sad	☐ Refuses to do work	☐ Perfectionistic
☐ Difficulty learning	☐ Neat/orderly	☐ Difficulty sitting still	☐ Anxious
☐ Conflicts with peers	☐ Withdrawn	☐ Difficulty paying attention	☐ Disorganized
☐ Doesn't make friends	☐ Disruptive	☐ Doesn't want to attend	☐ Aggressive

☐ Other _____

Is your child/adolescent currently employed? ☐ No ☐ Yes

If yes, where are they employed and how many hours/week?

_____

_____

Trauma History

Has your child experienced any of the following? (check all that apply)

- ☐ Physical abuse (either by adult or peer)
- ☐ Sexual molestation, sexual abuse, rape
- ☐ Emotional abuse or neglect
- ☐ Death of parent, sibling, close relative, or friend
- ☐ Alcohol or drug abuse by a parent or sibling
- ☐ Witnessed violence or abuse of others in the home
- ☐ Serious illness or disability of a close relative
- ☐ Bullying
- ☐ Frequent changes of school
- ☐ Frequent moves
- ☐ Criminal arrest and/or court proceeding
- ☐ Separation from one or both parents for an extended period of time
- ☐ Other situations that may have been disruptive or traumatic for your child: _____

_____

_____

Please provide any other information that you feel is important about your child:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Form Completed by: _____

Signature: _____ Date: _____

Reviewed by Clinician: _____ Date: _____