



Standard Intake Questionnaire-Child

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- Anxiety
- Appetite Issues
- Avoidance
- Crying Spells
- Depression
- Excessive Energy
- Fatigue
- Guilt
- Hallucinations
- Impulsivity
- Irritability
- Libido Changes
- Loss of Interest
- Panic Attacks
- Racing Thoughts

- Risky Activity
- Sleep Changes
- Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Are you a member of a religion/spiritual group?:

Do you have a current IEP?:

Have you ever been arrested? If yes, when and why?:

(check all that apply)

Do you drink caffeinated beverages? If yes, how many per day?:

Additional

Anything else you want the doctor to know?:

Enter title: