Anderson Hills Pediatrics
(513)-232-8100

Date: _______________

INTAKE QUESTIONNAIRE

CONFIDENTIAL AND PRIVILEGED INFORMATION

Please print or type. Answer all questions as well as you can. **Your completion of this questionnaire will help decrease the time needed to make an accurate evaluation of your child/teen's difficulties, as well as help to focus attention to your most relevant concerns.** If you do not understand any of the questions, please feel free to call our office at the above telephone number.

IDENTIFYING INFORMATION

Child/Teen's Name ____
Last First Middle

Child/Teen's birthdate: ________________________________ Age: __________
Month Day Year

Gender: □ Male □ Female □ Other ________________ Race/Ethnicity __________________________

Who has legal custody of the child/teen? ____

Please describe any shared or joint custody arrangements: __________________________________

____

____

____

If applicable, is your child's other parent aware of treatment? □ Yes □ No Supportive of treatment? □ Yes □ No

(Please be aware that it is our policy to contact the child's other parent regarding treatment if parents are not together)

FAMILY HISTORY

Parent's name ____ D.O.B. ____________________
First Last

Parent's occupation ______________________________

Does this parent have a history of: □ Depression □ Bipolar Disorder □ Anxiety/Panic Attacks □ ADHD
□ Substance Abuse □ Learning disorder □ OCD □ Chronic medical problem ___________________________
□ Other ____

Parent's name ____ D.O.B. ____________________

First Last

Parent's occupation ______________________________

Does this parent have a history of: □ Depression □ Bipolar Disorder □ Anxiety/Panic Attacks □ ADHD

□ Substance Abuse □ Learning disorder □ OCD □ Chronic medical problem ______________________________

□ Other ____

Is your child/teen adopted? □ Yes □ No If yes, for how long and by whom? _________________________

Are parents married/partnered? □ Yes □ No If yes, when?______________________________

Are parents currently separated? □ Yes □ No If yes, when?______________________________

Are parents divorced? □ Yes □ No If yes, when?______________________________

With whom does the child/teen primarily live? *(Please feel free to continue on back or another sheet as needed)*

Name	Relationship	Age

If the child also resides in another parent's/caregiver's home, please list the other household members:

Name	Relationship	Age

What is the primary language spoken in the child's/teen's home(s)? ________________________________

Does anyone else in the family (grandparent, sibling, aunt/uncle, cousins, etc.) have a history of:

□ Depression □Bipolar Disorder □ Anxiety/Panic Attacks □ ADHD

□ Learning Disorder □ Schizophrenia □ Autism Spectrum Disorder □ OCD

□ Other ____

BIRTH and DEVELOPMENTAL HISTORY

Did biological mother use/experience any of the following during pregnancy?

Tobacco □ Yes □ No

Alcohol □ Yes □ No

Drugs □ Yes □ No

Prescription Medication □ Yes □ No

Emotional Stress □ Yes □ No

Were there any difficulties with pregnancy: □ Yes □ No

If yes, please describe: ____

____

Length of pregnancy □ Full-term □ Premature: _______ weeks Birth weight _____________________

Were there any difficulties with delivery: □ Yes □ No

If yes, please describe: ____

Were there any medical problems at or immediately following birth? □ Yes □ No

If yes, please describe: ____

Were there any concerns with your child/teen's fine or gross motor development? □ Yes □ No

If yes, please describe: ____

Were there any concerns with your child/teen's speech or language development? □ Yes □ No

If yes, please describe: ____

Please indicate any difficulties your child/teen has had with the following:

Toileting □ In the past □ Currently □ Never Describe:___________________________________

Eating □ In the past □ Currently □ Never Describe:___________________________________

Sleeping □ In the past □ Currently □ Never Describe:___________________________________

Has your child ever received: □ Physical Therapy □ Occupational Therapy □ Speech/language Therapy

If yes, please describe: ____

____

MEDICAL HISTORY

(If you need more room, feel free to add your own page)

Describe any serious accident, illness or injury which your child/teen has had and at what age:

____

____

Has your child/teen taken any previous medications for emotional or behavioral concerns?

□ Yes □ No

If yes, please list medications, when the medication was taken, and reason for stopping the medication:

____

____

____

SCHOOL HISTORY

Attended pre-school? □ Yes □ No
Attended kindergarten? □ Yes □ No

In special classes (have an IEP/504 plan?) □ Yes □No
(If yes, please bring in a copy of the IEP/504 plan to your first appointment)

Repeated grade(s)? □ Yes □ No

If yes, please note grade(s) repeated and explain? ____

____

Ever had psychological testing at school? □ Yes □ No
(If so, please attach a copy of the report or have a copy sent to us.)

Ever been suspended/expelled? □ Yes □ No

If yes, please note in what grade(s) and reason: ____

____

School now attending: ____ Grade __________

Name of classroom teacher: ____

Telephone number of school: ___________________

SOCIAL HISTORY

Tell us about child/teen's friends: □ Has many friends □ Has a few friends □ Has no/very few friends

Are friends mostly: □ Of the same age □ Older □ Younger

Has your child had problems with: □ Being bullied □ Bullying others □Making Friends □ Keeping friends □ Hitting others/Aggression □ Shyness

Describe any social concerns: ____

____

Is your child involved in any activities (school, sports, clubs, religious)? □ Yes □ No

If yes, please list: ____

What are your child's/teen's favorite activities in his/her free time? _________________________

____

Has your child/teen ever had part-time work? □Yes □ No

If yes, please describe: ____

LEGAL HISTORY

Has your child/teen ever been arrested or involved with the juvenile court? □ Yes □ No

If yes, please explain: ____

____

HISTORY OF THE CURRENT PROBLEM

What is/are the problems that brings your child/teen to Mental Health services? *(Feel free to attach other sheets if needed)*

____

____

____

At what age was the child/teen's problem first noticed? ______________________________

Please describe any illness or injury that may have been associated with the problem:

____

Has your child/teen ever had treatment for this problem? □ Yes □ No

Where?______________________________ When? ____________________

Has your child/teen had psychological treatment for any other problem? □ Yes □ No

If yes, where? ______________________________ When? ____________________

SAFETY CONCERNS

Has your child/teen expressed any thoughts of killing her/himself? □ Yes □ No

Has your child/teen ever made a suicide attempt? □ Yes □ No

Has your child/teen ever made a threat of killing someone else? □ Yes □ No

Has your child/teen ever harmed his/her own body on purpose? □Yes □ No

If you answered yes to any of these questions, please explain: ______________________________

____

____

SUBSTANCE USE

If your child/teen is age 12 or older, do you have concerns that she or he is using any of the following?

Tobacco	□ Yes	□ No	□ Not sure
Alcohol	□ Yes	□ No	□ Not sure
Drugs	□ Yes	□ No	□ Not sure

If yes, please explain: ____

CHILD/TEEN and FAMILY STRESSORS

Has your child/teen or your family experienced any past or current stressors that may be important in understanding your child (divorce/separation, deaths, losses, relocations, traumas, etc.) □ Yes □ No

If yes, please explain ____

____

____

PLEASE LIST ANY GOALS YOU HAVE FOR YOUR CHILD'S/TEEN'S TREATMENT

____

____

____

Please tell us anything else you think will be of help in our understanding your child/teen. Include any questions that you would like us to answer. Feel free to add your own page if you need more room.

____

____

____

____

Thank you for taking the time to complete this questionnaire!

Signature of person filling out form: ____

Relationship to the child/teen: ______________________________ Date ________________