young mind center

# INTAKE QUESTIONNAIRE

**Please complete all items.** Write N/A for items that do not apply to you. Note any item(s) that you are unsure how to answer. The psychologist/clinician will review the form with you and answer any questions during the initial interview.

First and last name of person completing form: _____

Relationship to client: _____ Date of completion: _____

## Reason for Referral

Who referred you, or how did you find us? _____

What type of services are you seeking?

◯ Assessment ◯ Consultation ◯ Individual Therapy ◯ ABA Therapy ◯ Unsure

What are your concerns? (please use additional page(s) if needed) _____

_____

_____

_____

_____

How long have you had these concerns? _____

Do any of your family members or relatives have a similar problem? ◯ Yes ◯ No If yes, please note relation to client and age (if known) _____

What are your primary goals for this evaluation?

1. _____

2. _____

3. _____

## Client/Child Information

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____ Gender: ◯ Male ◯ Female ◯ Non-binary/third gender

Date of Birth: _____ (month / day / year) Place of birth: _____ (city / state)

Address: _____ (street / city / state / zip code)

County of Residence: _____ School District of Residence: _____

Primary Phone: ( _____ ) _____ E-mail: _____

Confidential voicemail? ◯ Yes ◉ No

With whom does the client live? _____

Educational Setting: ◯ Public ◯ Charter ◯ Private ◯ Homeschool ◯ Daycare ◯ N/A

Individualized Education Plan? ◯ Yes* ◯ No Educational Eligibility Category(s): _____

*If yes, please include copies of most recent MET and IEP reports.

School / Daycare Name(s): _____

School District: _____

Grade: _____ Teacher(s) / Instructor(s) Name: _____

Client's Employment Status: ◯ Employed ◯ Unemployed ◯ Never Employed

If employed or unemployed, list current or former employer: _____

**Parent/Guardian Information**

Parent/Guardian 1: ◯ Biological parent ◯ Adoptive parent ◯ Stepparent ◯ Guardian ◯ Other

Name: _____ Date of Birth: _____

Address: _____
street / city / state / zip code

County of Residence: _____ Home Phone: ( _____ ) _____

E-mail: _____ Cell Phone: ( _____ ) _____

Occupation (if applicable): _____ Work Phone: ( _____ ) _____

Highest level of education completed: _____

Parent/Guardian 2: ◯ Biological parent ◯ Adoptive parent ◯ Stepparent ◯ Guardian ◯ Other

Name: _____ Date of Birth: _____
☐ check here if same address as Parent/Guardian 1 and skip to e-mail

Address: _____
street / city / state / zip code

County of Residence: _____ Home Phone: ( _____ ) _____

E-mail: _____ Cell Phone: ( _____ ) _____

Occupation (if applicable): _____ Work Phone: ( _____ ) _____

Highest level of education completed: _____

Parent/Guardian Relationship Status:

◯ Married ◯ Domestic Partners ◯ Long-term relationship ◯ Divorced ◯ Separated ◯ Never married

Additional Parent(s)/Guardian(s): ◯ Adoptive parent(s) ◯ Stepparent(s) ◯ Guardian(s) ◯ Other

Name: _____ Date of Birth: _____

Address: _____

street / city / state / zip code

County of Residence: _____ Home Phone: ( _____ ) _____

E-mail: _____ Cell Phone: ( _____ ) _____

Occupation (if applicable): _____Work Phone: ( _____ ) _____

Highest level of education completed: _____

**Siblings**: List all full, half, stepbrothers and sisters of child, in birth order.

| Name | Gender | Age | Relationship to Child/Client | Live in Home |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | ◯ Yes ◯ No |
| _____ | _____ | _____ | _____ | ◯ Yes ◯ No |
| _____ | _____ | _____ | _____ | ◯ Yes ◯ No |
| _____ | _____ | _____ | _____ | ◯ Yes ◯ No |
| _____ | _____ | _____ | _____ | ◯ Yes ◯ No |
| _____ | _____ | _____ | _____ | ◯ Yes ◯ No |

**Other individuals living in the household**: ◯ Yes ◯ No

If yes, list names and relationship to the child. _____

_____

## Family History

Describe any history of developmental delays, learning difficulties, behavioral challenges, mental health disorders, and/or medical conditions in family members: _____

_____

_____

_____

_____

## Developmental History

Did mother use any of the following during pregnancy?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tobacco: | ◯ Yes | ◯ No | ◯ Unknown | If yes, frequency: | ◯ Occasionally | ◯ Daily | ◯ Weekly | ◯ Unknown |
| Alcohol: | ◯ Yes | ◯ No | ◯ Unknown | If yes, frequency: | ◯ Occasionally | ◯ Daily | ◯ Weekly | ◯ Unknown |
| Drugs: | ◯ Yes | ◯ No | ◯ Unknown | If yes, frequency: | ◯ Occasionally | ◯ Daily | ◯ Weekly | ◯ Unknown |

Planned pregnancy? O Yes O No
Natural conception? O Yes O No If no, please note procedure used: _____

Length of pregnancy:_____ Birth weight: _____

Delivery method (e.g., C-section): _____

Describe any difficulties or complications during pregnancy and/or delivery/post-delivery:_____

_____

_____

_____

Developmental Milestones

List age (in months) at which your child did the following: Check one: ◯ Approximated ◯ Exact

| Motor | Language |
|---|---|
| Sat alone: _____ | Babbling/Cooing: _____ |
| Crawled: _____ | First Words: _____ |
| Stood alone: _____ | Combined 2 words: _____ |
| Walked alone: _____ | Used 3-4 word sentences: _____ |

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

Toileting: ◯ Current ◯ Past ◯ Never If ever, describe: _____
Eating: ◯ Current ◯ Past ◯ Never If ever, describe: _____
Sleeping: ◯ Current ◯ Past ◯ Never If ever, describe: _____

**Medical & Behavioral Health History of Child/Client** (Please use additional page if needed)
Primary Care Physician: ◯ Yes ◯ No

Name: _____ Specialty: _____

Address: _____
street / city / state / zip code

Phone: ( _____ ) _____

Other Healthcare Provider(s): ◯ Yes ◯ No

Name: _____ Specialty: _____

Address: _____
street / city / state / zip code

Phone: ( _____ ) _____

Name: _____ Specialty: _____

Address: _____
street / city / state / zip code

Phone: ( _____ ) _____

Allergies, medical conditions, and/or mental health disorders? ◯ Yes ◯ No If yes, explain: _____

_____

_____

_____

Serious illnesses or hospitalizations? ◯ Yes ◯ No If yes, explain: _____

_____

_____

_____

List any medication or supplements child/client is receiving: (Please use additional pages, if needed)

| Medication | Dosage | Time(s) given |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Describe your child's eating habits: _____

Special diet and/or food allergies? ◯ Yes ◯ No If yes, explain: _____

_____

**Social-Emotional & Behavioral History**

Please indicate if you have concerns related to any of the following issues with your child/client, either currently or in the past:

- ◯ Does not follow instructions
- ◯ Difficulty paying attention
- ◯ Excessive crying/tantrums
- ◯ Difficulty interacting with peers
- ◯ Withdrawn/avoids interactions
- ◯ Unusual/repetitive behaviors
- ◯ Rigid behavior, routines, rituals
- ◯ Unhappy/sad
- ◯ Moody/irritable
- ◯ Anxious/worries
- ◯ Hypo-/hypersensitive to any of senses
- ◯ Harm to other people or animals
- ◯ Self-injurious behavior
- ◯ Preoccupations, obsessions
- ◯ Acts without thinking
- ◯ Overactive
- ◯ Underactive/lacks energy
- ◯ Excessive fears
- ◯ Overly familiar with strangers
- ◯ Unaware of environmental dangers
- ◯ Sexually precocious behavior

Has your child/client experienced any of the following?

- ◯ Move to a new home/school
- ◯ Death in the family
- ◯ Serious illness of family member
- ◯ Bullying
- ◯ Family financial stress
- ◯ Witnessed abuse
- ◯ Experienced abuse
- ◯ Neglect
- ◯ Parent separation/divorce
- ◯ Parental conflict
- ◯ Incarcerated parent
- ◯ Traumatic event

**Previous Evaluations** ◯Yes* ◯No

*If yes, please include copies of most recent MET and IEP reports.

| Date (month/year) | Evaluator (name, credentials) | Facility (e.g., name of clinic) | Reason for Testing (e.g., delayed speech) |
|---|---|---|---|
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**Educational History**

List all schools attended, including preschool and/or daycare.

| School/Facility Name | Type of Classroom (e.g., multi-age/grade, mainstream, integrated, self-contained, etc.) | Grade(s) (indicate if repeated) | Dates Attended (month/year – month/year) |
|---|---|---|---|
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Ever suspended or expelled? ◯Yes ◯No If yes, what grade(s)? _____

Explain incident & consequence/resolution: _____

_____

_____

_____

**Services Received** (Include current and previous services)

| Type of Service (speech therapy) | Location (clinic, home, school) | Provider (name, credentials) | Duration/Frequency (60 min/wk) | Dates (6/10 – present) |
|---|---|---|---|---|
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**Extracurricular / Group Activities** (include social groups, clubs, sports teams, etc.)

| Activity (e.g., soccer) | Organization/Location (city league) | Duration/Frequency (2hrs; 2x/week) | Dates (6/10 – present) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Community Organizations Resources**

Does the client or your family participate in other community-based programs or resources? (e.g., religious group, support group, social services, etc.) ◯ Yes ◯ No If yes, please list: _____

_____

**Strengths of the Child/Client and Family**

Please tell us about your/your child's and family's strengths: _____

_____

Please tell us anything else you think would be helpful in understanding you or your child. Include any questions you may have.

_____

_____

_____

***Thank you for taking the time to complete this questionnaire!***

By signing this form, I attest the information provided is true and accurate to the best of my knowledge.

_____

Printed Name Signature Date