Brighter Hope Wellness Center

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CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Form Completed By:_____ Date:_____

PATIENT & FAMILY INFORMATION

Child/Adolescent's Full Name:_____

Preferred Name/Nickname:_____ Birthdate:_____

Gender:_____ Race/Ethnicity:_____

Address:_____

_____

Pediatrician:_____ Referred by:_____

Parent/Guardian/Caregiver's Name:	Parent/Guardian/Caregiver's Name:
_____	_____
Birthdate:_____	Birthdate:_____
Address (if different from child's):	Address (if different from child's):
_____	_____
_____	_____
Cell Phone:_____	Cell Phone:_____
Home Phone:_____	Home Phone:_____
Email:_____	Email:_____
Employed: ❑No ❑Yes	Employed: ❑No ❑Yes
Title: _____	Title: _____
Location:_____	Location:_____
Work Phone:_____	Work Phone:_____
❑ Married ❑ Divorced ❑ Remarried ❑ Never married	❑ Married ❑ Divorced ❑ Remarried ❑ Never married
❑ Other: _____	❑ Other: _____

If parents are not married to each other, date of divorce: _____

Name of person(s) with legal custody of child:_____
(PROVIDE A COPY OF THE SEPARATION/DIVORCE DOCUMENTS PERTAINING TO CUSTODY)

Permission for Assessment

I give my permission for my child, _____, to be evaluated and assessed by Brighter Hope Wellness Center to determine initial and continuing eligibility for services. I understand that this process is for directing treatment and not necessarily as part of a formal psychological testing/evaluation. I also understand that formal psychosocial testing/evaluation requires additional services. Finally, I understand that this information will also be used to identify my child's strengths and needs to provide appropriate intervention services and programming.

Print Child's Full Name:	Child's D.O.B.
Parent / Guardian Signature(s):	Date:
Brighter Hope Wellness Center Employee Signature:	Date:

If the child is adopted, child's age at time of adoption & country of birth:_____

List any other persons who are authorized to drop off or pick up or stay with the child:

Name	Relationship & Age	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any other persons who live in the same household as the child:

Name	Relationship & Age	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SCHOOL/ACADEMIC

School Name:_____ Grade:_____

Teacher's Name:_____ Teacher's Name:_____

Phone Number:_____ Fax Number:_____

Email Address: _____

Address:_____

_____

Performance in school:_____

_____

_____

Educational Programming:

- ❑ Advanced/Gifted
- ❑ Special Education (inclusion)
- ❑ Mainstream/Regular Education
- ❑ Special Education (self-contained)
- ❑ Private School
- ❑ Daycare
- ❑ My child currently has an IEP
- ❑ My child currently has a 504 Plan

DEVELOPMENT

Pregnancy & Delivery

Describe healthcare and medical illnesses during pregnancy:_____

_____

Delivered via: ❑C-Section ❑Vaginally ❑Vaginal birth after c-section (VBAC)

Was the child premature? ❑ No ❑ Yes Born at how many weeks old: _____

Weight at birth: _____ Length at birth:_____

Describe the delivery and any birthing complications:_____

_____

Infancy

Illnesses as a newborn:_____

_____

Feeding habits during first year of life:_____

_____

Sleeping habits during first year of life :_____

_____

Any other difficulties during the first year of life:_____

_____

Milestones

Approximate age at which:

Child walked alone:_____ Spoke in simple sentences: _____

Toilet Trained: Bladder_____ Bowel _____

Does child have bladder control: ❑ No ❑ Yes Bowel control: ❑ No ❑ Yes

Accidents during the day: ❑ No ❑ Yes, how often?_____

Accidents during the night: ❑ No ❑ Yes, how often?_____

Speech, hearing, or language difficulties:_____

_____

PHYSICAL HEALTH

Current height: _____Current weight:_____

GENERAL:
How do you rate your/your child's overall health?
Excellent ❑
Very good ❑
Good ❑
Not very good ❑
Poor ❑

NOSE/SINUSES:
Itching/sneezing ❑
Drainage, Color ❑
Change in sense of smell ❑
Congestion ❑
Symptoms all year long ❑
Frequent sinus infection ❑
Nasal polyps ❑
Snoring ❑
CT Scan of sinuses ❑
Mouth breathing ❑
Other: _____
What season are they worse? _____

SKIN:
Rashes (please tell us the location) ❑_____
Itching (please tell us the location) ❑_____
Hives (please tell us the location) ❑_____
Swelling (please tell us the location) ❑_____
Eczema (please tell us the location) ❑_____
Other: _____

HEAD:
Headaches ❑
Recent head trauma ❑
Other: _____

THROAT:
Itching ❑
Postnasal drip ❑
Bad breath ❑
Soreness ❑
Throat clearing ❑
Thrush (yeast infection) ❑
Change in voice ❑
Other: _____

EYES:
Itching/burning ❑
Tears/discharge ❑
Redness ❑
Swelling ❑
Eyelid irritation ❑
Painful with light ❑
Other: _____

GASTROINTESTINAL
Nausea/vomiting ❑
Diarrhea ❑
Heartburn/reflux ❑
Abdominal pain ❑
GERD ❑
Hernia ❑
Other: _____

MUSCLE AND BONE: ❑
Painful or swollen joints ❑
Stiffness ❑
Muscle weakness ❑
Back pain ❑
Other: _____

PHYSICAL HEALTH (cont)

LUNGS:

Cough ❑
Shortness of breath ❑
Sputum production ❑
Wheezing ❑
Chest tightness ❑
Bloody sputum ❑
Other: _____

What triggers their breathing problems?

Vigorous play ❑
Colds ❑
Pollen ❑
Emotions ❑
Animals ❑
Cold air ❑
Dust ❑
Weather change ❑

Do they wake up in the night because of breathing problems? _____

How often? _____ (night/week/month)

NERVOUS SYSTEM AND BRAIN

Weakness/clumsiness ❑
Numbness ❑
Tingling/burning ❑
Speech delay ❑
Delayed development ❑
Seizures ❑
Loss of consciousness ❑
High Fever ❑
Other: _____

HEART

Chest pain ❑
Ankle swelling ❑
Heart palpitations ❑
Other: _____

URINARY TRACT

Frequent bladder infections ❑
Frequent urination ❑
Trouble starting urine ❑
Loss of urine with cough or sneeze ❑
Other: _____

BLOOD AND METABOLISM

Easy bleeding/bruising ❑
Swollen lymph nodes ❑
History of thyroid disease ❑
History of diabetes ❑
Other: _____

OTHER:

Cancer ❑
Please indicate:

_____

REPRODUCTION

Sexually active ❑
Pregnant or planning on pregnancy ❑
Breast feeding ❑
History of yeast infection ❑
Other: _____

OTHER PSYCHOLOGICAL AND BEHAVIORAL

Sleeping issues (please comment)

_____

_____

Feeding/eating issues (please comment)

_____

_____

Use this space to further explain any of the above:_____

_____
_____
_____
_____
_____
_____

Medications/Supplements/Vitamins

Name	Dosage	Person prescribing (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations

Name of Hospital	Reason for Hospitalization	Dates of Stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENTAL/BEHAVIORAL HEALTH

Family History (if known)

1. Family of Biological Parent (be sure to specify which one):_____

_____

2. Family of Biological Parent (be sure to specify which one):_____

_____

Household Stressors

❑ Financial ❑ Health ❑ Legal ❑ Abuse/Neglect/Trauma (current or history of)

❑ Other:_____

Use this space to further explain any of the above:_____

_____

Prior Mental Health Services

Name of Clinician	Reason for Services	Dates Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

Problems the child is experiencing (reasons for pursuing services at this time):

_____

_____

_____

_____

_____

_____

_____

_____

Current symptoms

❑ Alcohol/substance use	❑ Aggression	❑ Abuse	❑ Angry
❑ Anxiety	❑ Attention problems	❑ Argues	❑ Cruel to animals
❑ Cheating	❑ Developmental delay	❑ Disobedient/stubborn	❑ Eating problems
❑ Energy (hyperactive)	❑ Low energy	❑ Fearful	❑ Fighting
❑ Hair pulling	❑ Immature	❑ Impulsive	❑ Irritable
❑ Learning problems	❑ Lying	❑ Moody	❑ Nail biting
❑ Nightmares	❑ Runs away	❑ Sad	❑ Self-harm
❑ Shy	❑ Risky behavior	❑ Rituals	❑ Social problems
❑ Suicidal	❑ Swearing/cursing	❑ School refusal	❑ Tantrums/meltdowns
❑ Teased/bullied	❑ Teasing/bullying	❑ Uncoordinated/" clumsy"	❑ Wetting the bed
❑ Colic	❑ Other: _____		

When did these problems begin:

_____

_____

_____

SOCIAL/FRIENDSHIPS

Does your child have friends?

Does your child have a best friend?

Do other children seek out your child to play with?

Describe your child's friendships:_____

_____

INTERESTS/BELIEFS/PERSONALITY

Religious, spiritual, or cultural/ethnic beliefs:_____

_____

Child's interests:_____

_____

Child's activities:_____

_____

Child's strengths:_____

_____

Child's achievements:_____

_____

PARENT-CHILD ACTIVITIES

Top 3 activities you like to do with your child:

1)_____

_____

2)_____

_____

3)_____

_____

Activities you wish you could enjoy with your child, but at this time, do not seem possible:

1)_____

_____

2)_____

_____

3)_____

_____

Have you observed overall improvement in your child's behavior and ability to learn new skills through previous behavior or mental health services? Please explain.

_____

_____

_____

In what areas/skills would like more parent training and support?

_____

_____

_____

ADDITIONAL COMMENTS

Use this space to write any additional comments or concerns about your child that would be helpful to know.

_____

_____

_____

_____

_____

_____