Child

Questionnaire for new clients

Patient Name: ______________________________

Date: ________________________________

How many sessions are you expecting to need? ☐ 1-10 ☐ 10-20 ☐ ongoing

What are your primary challenges that bring you to therapy?

What are you hoping to gain from therapy?

Circle any of the following abuses your child/dependent has experienced in the past or is currently experiencing: *Physical* *Emotional* *Verbal* *Sexual* *Neglect* *Witness of abuse*

List any current medical conditions/illnesses:

List any current medications: *(or attach list)*

Name	Dose	Frequency	Reason	Physician

List any past mental health or psychiatric history/treatment (i.e., past therapy, issues of self-harm or suicide attempts, use of medications, diagnoses):

List family history of mental health or substance abuse issues involving parents, siblings, grandparents, aunts/uncles (i.e., depression, anxiety, bipolar, suicide attempts):

Describe your child/dependent's strengths and weaknesses:

Name of person completing form:

____

Parents: **Please check any symptoms or experiences that you have observed in the last month.**

(A second copy of this checklist is included below for older children who may wish to report their own observations as well).

	Nightmares		Rapid mood changes
	Traumatic experience		Tantrums/angry outbursts
	Easily startled, feeling 'jumpy'		Lying/manipulation
	Intrusive memories		Self-harm (i.e., punching head, cutting, etc.)
	Fear of certain objects or situations (i.e., flying, heights, bugs, etc.)		Acts or threats of violence toward people/animals
	Panic attacks		Talking about killing self or others
	Repetitive behaviors or mental acts (i.e., counting, checking locks, washing hands)		Acts or threats of violence toward objects
			Unusual sexual behaviors
	Repetitive sounds or body movements (i.e., rocking, vocal sounds)		Bedtime wetting
	Fixations/Obsessions		Daytime wetting
	Difficulty making friends		Other:
	Sensory sensitivity		

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