

Living Well Counseling Services, LLC

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Child/Adolescent Intake Questionnaire

Today's date _____

Name: _____ Date of birth _____

Address: _____ State _____ Zip _____

Home phone _____ Work phone _____ email _____

Circle areas in which you've noted difficulties or changes: sleep, appetite, crying, concentration, weight, social interaction, sexual activity, physical pains or sickness, panic, unusual behavior, depressive thinking, frightening thoughts, suicidal thoughts.

(For office use only)
Presenting problems:

Have you experienced any significant life changes in the past year?

Explain _____

Have you previously been in therapy? Yes No

Previous therapy was related to _____

List previous counseling experience, including dates and your response to therapy _____

Have you recently been on any medications? Yes No

Type and dosage _____

Physician's name, address, phone _____

Health concerns:

Have you ever been hospitalized? Yes No

Dates and reason _____

AODA History:

Do you use alcohol? Yes No

Type, Amount & Frequency _____

Do you use tranquilizers (valium, librium, xanax, etc.), narcotics, cocaine, marijuana, amphetamines, or other substances?

Yes No

Describe _____

Where did you grow up? _____

(For office use only)

Father's name _____ Age _____

Family history:

Occupation _____

Health _____

Marital status _____

If deceased, age, year, cause of death _____

Mother's name _____ Age _____

Occupation _____

Health _____

Marital status _____

If deceased, age, year, cause of death _____

Siblings (include age)

Is there any illness or disorder that tends to run in your family?

Yes No Please explain _____

Have any of your family (grandparents, parents, aunts/uncles, your siblings or your children) had any problems with the following?

	Relative	Treatment
Alcohol/drug abuse		

Depression

Bi-polar disorder

Suicide

Other emotional disorders

Current grade: _____ Current School: _____

Education Info:

Favorite subjects: _____

Least favorite subjects: _____

How many schools have you attended? _____

Have you received any testing or counseling in school? Yes No

Do you attend any special education classes? _____

How do you get along with classmates? _____

(Office use)
Social interaction/support:

How do you get along with teachers? _____

What chores and responsibilities do you have? _____

How many close friends do you have? Male _____ Female _____

Please list hobbies, clubs, sports _____

How do you use free time? _____

Your present living situation: (circle one)
both parents one parent shared custody guardian/foster

Religious History:

Religious upbringing and current involvement _____

Is there any other information about you or your family that would be helpful for us to know? _____

Client's signature

Clinician's signature