Intake Questionnaire – Child History

Counseling & Assessment Clinic (CAC)
Texas A&M University, MS 4225
College Station, TX 77843-4225

A. Identification

Today's Date: _____/ _____/ _____

Your child's name: _____ Date of Birth ____/ _____/ _____

Age: _____ Ethnicity_____

Home street address: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____

Person completing this form: _____ Relation to child:_____

B. Referral: By whom were you referred to us? _____
Why have you come to the Counseling & Assessment Clinic today?

_____

_____

_____

_____

_____

_____

_____

C. Parents (Number of adults in the home? _____)

Mother: _____ Age: _____ Occupation: _____

Father: _____ Age : _____ Occupation: _____

Other parent figure: _____ Age : _____ Occupation: _____

How does the child get along with his/her mother ? _____

_____

How does the child get along with his/her father ? _____

_____

D. Child's School History

Dates				Adjustment
From	To	School	Special Classes	to school
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has child ever been retained or skipped a grade? Yes / No If yes, explain:

E. Siblings **(Number of siblings in the home? _____)**

Name	Age	Sex (circle)	Highest grade completed	Occupation	Present health
_____	___	M or F	_____	_____	_____
_____	___	M or F	_____	_____	_____
_____	___	M or F	_____	_____	_____
_____	___	M or F	_____	_____	_____

F. Relatives

Have any relatives of this child experienced learning difficulties in school? (Circle) Yes No

Explain: _____

_____

_____

_____

Have any relatives of this child been seen by a mental health professional? (Circle) Yes No

Explain:_____

_____

H. Medical History:

1. Pregnancy:

What illness or difficulties did the mother have during pregnancy? _____

_____

Length of pregnancy: _____ months

Did the mother have any previous miscarriages? (Circle) Yes No

2. Birth:

Length of labor: _____ hours

Delivery was: __ normal __ easy __ difficult

Was the child healthy at birth? _____

Weight at birth _____ pounds _____ ounces

Have the child ever had a serious head injury? (Circle) Yes No Please explain, giving approximate age:

_____

_____

Has the child been hospitalized? (Circle) Yes No

Explain: _____

_____

_____

Does the child take any medications? (Circle) Yes No

Explain: _____

_____

_____

I. Developmental Information

Please note the approximate ages that the following occurred:

_____ Sat alone _____ Talked in single words

_____ Crawled _____ Talked in sentences

_____ Toilet Trained _____ Walked

Has child had any development problems such as speech difficulties, communicating with others, carrying out instructions? (Circle) Yes No

Explain:_____

_____

_____

_____

J. Behavior

Would you consider your child to be: __Overactive __ Fidgety __ Average __ Underactive

Length of attention span: __ Long __ Average __ Short

Check anything that the child has had any trouble with:

_____ running _____ skipping _____ eating _____ writing _____crying
_____ tiredness _____ riding a bike _____ vision _____ speaking _____ sleeping
_____ aggression _____ playing alone _____ bedwetting _____ temper tantrums _____ irritability
_____ nightmares _____ sleepwalking _____ soiling _____ playing with others

Does your child get along well with other children? (Circle) Yes No

Explain: _____

_____

_____

Does your child require much discipline? (Circle) Yes No

Explain: _____

_____

_____

What types of discipline are used most regularly? _____

_____

_____

_____

K. School Adjustment

Does your child like school? __ Yes __ No

What subject does he/she like best?_____

Least? _____

Name some activities your child enjoys: _____

Have your or your child's teacher notices any letter, number, or word reversals? ? (Circle) Yes No

Explain:_____

_____

Has your child's teacher observed any learning problems? (Circle) Yes No

Explain: _____

_____

_____

Has your child ever been placed in any special classes? (Circle) Yes No

Explain: _____

_____

_____

What, if any, behavior problems have you or the child's teacher observed with this child? _____

_____

_____

Has your child ever been evaluated or had any previous psychological or educational evaluations? If so, give name, date and place of evaluation: _____

_____

_____

_____

Has your child has any special interventions in school? (Circle) Yes No

Explain: _____

_____

_____

Please add any other additional information which you feel would be beneficial to us including any family problems which may have affected your child's school performance: _____

_____

_____

_____

_____

L. Additional Information about your Appointment

Please answer the following three questions. Just circle the number that shows how you feel.

a. How serious are your child's problems? (circle one number)

0	1	2	3	4	5	6	7	8	9	10
Not Serious										Extremely Serious

b. How important is it for your child to get over his/her problems soon?

0	1	2	3	4	5	6	7	8	9	10
Not Important										Extremely Important

c. How much do you think it will help your child to get to the mental health center?

0	1	2	3	4	5	6	7	8	9	10
Will Not Help At All										Will Really Help A Lot