Kent Island Psychology

Larry Lynn, II, Psy.D
Phone : 443.249.3213
Fax : 443.249.3214
102 East Main Street, Suite 101
Stevensville, Maryland 21666
www.KentIslandPsychology.com

Intake Questionnaire - Child

Client's Name ____ *Date of Birth*______________________

Name of person completing Questionnaire ______________________________ *Relationship* __________________________

In the case of parental divorce only: Do you have authority to provide consent for this child's treatment? Yes / No

1. Please provide a brief statement explaining why you have scheduled this appointment:

____

____

____

____

2. Has this client previously been in therapy/counseling? Yes _____ No ____

Name of Provider ______________________________ Dates of service _______________

Name of Provider ______________________________ Dates of service _______________

3. Please indicate who lives with the client, their age, and the client's relationship to that person (e.g., parent, sibling). If there are multiple homes, please indicate the visitation schedule.

____

____

4. Has the client been diagnosed with a medical or neurological problem? Yes _____ No ____

If yes, please indicate the diagnosis(es) ____
If yes, is the client currently receiving services for the problem? Yes _____ No ____

5. Has the client been hospitalized for psychiatric reasons? Yes _____ No ____

If yes, when ______________________ and where ____________________________________
Additional: when _____________________ and where ___________________________________

6. What psychiatric medications is the client currently prescribed? None _________

Name of medication	Dose	Compliant? (Always, Sometimes, Rarely)

7. What non-psychiatric medications are being prescribed at this time? None _________

Name of medication	Dose	Compliant? (Always, Sometimes, Rarely)

8. What psychiatric medications have been prescribed in the past? None _________

Name of medication	Dose	Dates of use	Why was the prescription ended?

9. Does this client have an active IEP/504 at his/her school? Yes _____ No ____

10. Please indicate with a 'check' those issues concerning to this client; you may use more than one check as a means of indicating the severity of the problem:

	Depression – sad, unhappy		Shy/few friends
	Anxiety – nervous, worries a lot		Anger
	Defiant/breaks rules		Aggressive with others
	Fearful		Poor concentration
	School problems (i.e., grades)		Few interests
	Low self-esteem/lacks self-confidence		Gets teased a lot
	Physical complaints		Destroys things
	Quickly changes moods		Threatens to hurt/kill him or herself
	Drug/alcohol use		Dependent – Insufficient autonomy
	Inattentive – easily distracted		Homework problems
	Easily irritated – grumpy a lot		Ongoing conflict between parents
	Parents have or may divorce		Unusual or bizarre behavior
	Adoption issues		Poor social skills
	Disorganization		Emotional/Physical/Sexual Abuse
	Disrespectful to authority		Isolative – prefers to be alone
	Cuts or otherwise harms him/herself		Problems with weight/regulating food
	Sexual Problem		

11. How did you hear about our practice?

_____ Friend/Family member
_____ Psychologist/Psychiatrist/Social Worker
_____ Pediatrician/Medical Doctor
_____ Other (please describe) ___________________________________

(optional) The name of the person who referred you ___________________________