Hollywood Psychology Center

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Youth Intake Questionnaire for Parents/Guardians

Child's name _____ Age _____ Birthdate _____

Who referred you _____

Address _____ Phone # _____

This form was completed by _____

Relationship to child _____ Phone # _____

Family Physician/Pediatrician _____ Phone # _____

What is happening in your child's life that resulted in this appt? _____

When did the current problems start? _____

What were the stressors happening in the child's life at the time? _____

Has your child ever been treated by Psychiatrist/Psychologist/counselor? ☐ No ☐ Yes

If yes, provider's name _____ Date _____

Reason for treatment _____

Family Information Background

Mother _____ Age _____ Currently living w/child ☐ No ☐ Yes

Father _____ Age _____ Currently living w/child ☐ No ☐ Yes

Name of legal physical custodian _____

Names and ages of others living in the home:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Cultural background _____ Religious background _____

Medical History

Does the child have any significant health problems? ☐ No ☐ Yes ☐ Past ☐ Present

If yes please explain

Name of Physician monitoring this condition

Current Medications:

Name Dosage

Name Dosage

Name Dosage

Has the child ever been hospitalized? Surgeries? Serious injuries, broken bones, head injuries? ☐ No ☐ Yes

If yes please explain

Sleep Patterns

Past sleep problems ☐ No ☐ Yes Current sleep problems ☐ No ☐ Yes Problems staying asleep ☐ No ☐ Yes

Waking too early ☐ No ☐ Yes Frequent dreams/nightmares ☐ No ☐ Yes

What time does your child go to bed? How many hours of sleep does he/she get

Please check any/all of the following that you are concerned about regarding your child:

☐ divorce	☐ making decisions	☐ restlessness	☐ sexual abuse	☐ compulsions
☐ jealousy	☐ self-control	☐ short attention span	☐ shyness	☐ sadness
☐ stubbornness	☐ lying	☐ aggressive feelings	☐ confidence	☐ loneliness
☐ uncooperative	☐ cheating (at school)	☐ physical fighting	☐ anorexia	☐ temper
☐ headaches	☐ feeling alienated	☐ can't be alone	☐ panic attacks	☐ depression
☐ sleep trouble	☐ family conflict	☐ siblings	☐ drug use	☐ alcohol use
☐ guilt	☐ weight loss	☐ disorganized	☐ anger	☐ stress
☐ appetite	☐ weight gain	☐ losses, sadness: death	☐ sleep too much	☐ concentration
☐ friends	☐ low self-esteem	☐ sexual identity	☐ nightmares	☐ defiance
☐ unhappiness	☐ health problems	☐ destructive behavior	☐ fears	☐ skipping school
☐ school	☐ sexually active	☐ dating problems	☐ energy level	☐ teachers
☐ withdrawal	☐ suicidal feelings	☐ can't relax	☐ hate	☐ teasing

Other

Does your child hear or see things that are not there? ☐ No ☐ Yes

If yes, describe

Has your child been Physically/emotionally/sexually abused? ☐ No ☐ Yes

If yes please explain

Has your child been involved with the legal/criminal system? ☐ No ☐ Yes

If yes please explain

Are you aware of your child ever thinking/trying to hurt or kill themselves? ☐ No ☐ Yes

If so what are some of the details

What do you what to get out of counseling for your child? ☐ No ☐ Yes

Is there any family history of mental/behavioral health problems. ☐ No ☐ Yes

I certify all the above is true to the best of my knowledge

Signature of parent/guardian Date