MINOR INTAKE PARENT/GUARDIAN QUESTIONNAIRE

Personal Identity			
Legal Name:		Preferred Name:	
DOB:		Personal Pronouns:	
Race/Ethnicity:		Gender Identity:	
Sexual Identity:		Religious Affiliation:	
Primary Language:		Other Language(s):	
Other Identity Factors:			

Referral Information	
Referred By:	
Main Concern:	

Living Situation and Family Relationships	
Please describe the child's living situation including who is in the home, any shared custody arrangements, and moves/changes within the last several years:	
Does the family:	☐ Rent apartment ☐ Rent Home ☐ Own Home ☐ Resides with friends/family ☐ Currently homelessness
Please describe the child's relationship with parents, siblings, and other significant family members (note any significant changes):	

Family History	
Please note any family history of mental health/developmental concerns:	
Please note any family history of physical health concerns:	
Please note any family history of chemical health concerns:	
Pregnancy/Birth History	
Complications with pregnancy:	
Substance exposure in utero:	☐ Yes (please list: _____) ☐ No ☐ Unknown
Complications with labor/delivery:	
Post-Partum Mental Health Concerns:	☐ Post-Partum Anxiety ☐ Post-Partum Depression ☐ Post-Partum Psychosis ☐ Post-Partum Other (please list: _____) ☐ Unknown ☐ None
Please describe the child's health immediately after birth:	

Additional important pregnancy/birth information:	
Developmental History	
Please describe any concerns for developmental milestones (walking, talking, toileting, etc.):	
Has your child ever been assessed through the school district, Help Me Grow, or other entity:	
Please note any services and providers your child received between 0-6 years:	☐ Speech _____ ☐ Occupational Therapy _____ ☐ Physical Therapy _____ ☐ Mental Health _____ ☐ Other _____
Medical History	
Does your child have a history of any of the following concerns (please describe):	☐ Allergies _____ ☐ Asthma _____ ☐ Surgery _____ ☐ Head Injury _____ ☐ Hospitalization _____ ☐ Other Chronic Condition: _____ ☐ Vision Concerns: _____ ☐ Hearing Concerns: _____

Primary Care Physician:	
Please list any current medications and conditions being treated:	
Sleep concerns (please describe):	☐ Long time to fall asleep _____ ☐ Night waking _____ ☐ Nightmares _____ ☐ Bedwetting _____ ☐ Sleep changes _____ ☐ Other _____
Appetite/eating concerns (please describe):	☐ Excessively picky _____ ☐ No appetite _____ ☐ Binge eating _____ ☐ Restrictive eating _____ ☐ Appetite changes _____ ☐ Other _____
Mental Health History	
Please describe any mental health services received, approximate dates, and providers: (Includes evaluations, hospitalizations, residential care, intensive programs, therapy, etc.)	

Substance Use/Exposure	
Please describe any concerns for substance use by the child:	☐ Tobacco (includes vaping) _____ ☐ Alcohol _____ ☐ Drugs _____ ☐ Other _____
Please describe any exposure to substances through peers, family, etc.	☐ Tobacco (includes vaping) _____ ☐ Alcohol _____ ☐ Drugs _____ ☐ Other _____
Has the child ever received chemical health evaluation or treatment:	
Has anyone in the child's immediate family received chemical health treatment:	
Stressors/Trauma History	
Has the child experienced/witnessed any of the following:	☐ Car accident ☐ Significant illness (own) ☐ Death of a love one ☐ Emotional Abuse ☐ Neglect ☐ Sex Trafficking ☐ Community violence ☐ Bullying ☐ Incarceration (own) ☐ Witnessed violence act ☐ Other ☐ Natural Disaster ☐ Significant illness (other) ☐ Homelessness ☐ Physical abuse ☐ Sexual abuse ☐ Domestic violence ☐ Racial trauma/violence ☐ Significant parental conflict ☐ Incarceration (other) ☐ Animal incident (bite, aggression, etc.)

Please describe each incident including age of the child, whether the child was witness or participant, and potential impact on the child:	
Safety Concerns	
Please note and describe any current safety concerns:	☐ Suicidality _____ ☐ Self-Injury _____ ☐ Aggressive _____ ☐ Running away _____ ☐ Impulsivity _____ ☐ Other _____
Please describe any current safety plans or agreements in place:	
School Functioning	
Current School:	Grade:
Please note any changes to the child's school over the last several years:	
Is the child currently receiving school based services under a formal plan (please describe):	☐ IEP _____ ☐ 504 _____ ☐ Other _____
Please describe current academic functioning:	
Please describe current behavioral functioning:	

Any additional school concerns:	

Employment History

Please describe current employment (employer, name, general duties):	

Basic Needs

Please note any areas of unmet basic needs:

- ☐ Food
- ☐ Shelter
- ☐ Clothing
- ☐ Medical Care
- ☐ Education
- ☐ Transportation
- ☐ Other _____

Resources and Supports

Please describe any current resources or supports within the child's life:

- ☐ Sports, clubs, organizational involvement

_____

- ☐ Formal services (i.e. case management, support groups, therapy, etc.)

_____

- ☐ Church/faith community involvement

_____

- ☐ Extended family support

_____

- ☐ Volunteer Involvement

_____

- ☐ Other

_____

Behavior/Emotional Concerns

Behavior	What does it look like?	How often does it occur? How long does it last?	When did it start?
☐ Worries			

☐ Repetitive questions			
☐ Reassurance seeking			
☐ Irritability			
☐ Mood swings			
☐ Tantrums			
☐ Tearfulness			
☐ Withdrawn			
☐ Fatigue/low energy			
☐ Hyperactivity			
☐ Impulsivity			
☐ Hypervigilance			
☐ Task Avoidance			
☐ Difficulty organizing			
☐ Difficulty following multi-step directions			
☐ Self-esteem concerns			

☐ Self-deprecating language			
☐ Somatic complaints (stomach aches, headaches, etc.)			
☐ Reactivity			
☐ Difficulty with change			
☐ Poor concentration/focus			
☐ Easily distracted			
☐ Other			

Communication		
Please note any communication concerns:	☐ Literal communication	☐ Difficulty with sarcasm
	☐ Difficulty initiating conversation	☐ Blurting/interrupting
	☐ Repeated language	☐ Restricted topics
	☐ Difficulty maintaining conversation	☐ Difficulty conversing with adults
	☐ Difficulty conversing with peers	☐ Difficulty talking about feelings
Please describe any of the above:		

Play Skills	
Please describe your child's current play interests and skills:	
Please describe any previous concerns for play:	

Social Skills	
How does your child relate to peers:	
How does your child relate to adults:	
Please describe any concerns for social relationships:	
Please note any significant changes to your child's social skills/abilities/peer group:	
Sensory Motor and Self Help	
Please describe any of the following concerns:	Sensitivity to: ☐ Sound _____ ☐ Light _____ ☐ Textures _____ ☐ Temperature _____ ☐ Touch _____ ☐ Being dirty/wet _____ ☐ Sensory seeking (crashing, flipping upside down, spinning): _____ ☐ Repetitive movements (rocking, hand flapping, finger play): _____ ☐ Fidgeting: _____
Please describe your child's ability to meet self-care needs (dressing, brushing teeth, bathing, etc.):	

Strengths	
What do you see as your child's greatest strengths:	
What does your child see as their biggest strengths:	