



Psychology Intake Questionnaire

The following questionnaire is designed to assist with gathering information to understand your child's unique circumstances and guide treatment.

Child's name: _____ DOB: _____ Age: _____ Gender: _____

Person completing questionnaire & relationship to child: _____

Today's date: _____

Family members and household composition:

Name	Relationship	Age

Custody arrangements if applicable:

Are there any legal proceedings currently occurring Y/N. If so please provide details:

Briefly describe the concerns you have about your child or family situation:

When was the problem first noticed: _____

Please describe your child's strengths:

Please list your child's favourite activities:

1. _____ 2. _____ 3. _____

Please list your least favourite activities:

1. _____ 2. _____ 3. _____

Developmental History:

Were there any problems during pregnancy? If yes, please describe:

Was the birth mother taking any medications during pregnancy? If yes, please describe:

Term length: ☐ Full term ☐ Premature ____ (weeks) ☐ Late ____ (weeks)

Birth weight: _____

Any complications during birth? If yes, please describe:

Did your child experience any complications following birth? If yes, please describe:

The following is a list of infant and early childhood developmental milestones. Please indicate the approximate age when your child was able to do the following:

Behaviour	Age	Behaviour	Age
Showed response to parent	_____	Said several words together	_____
Rolled over	_____	Dressed self	_____
Crawled	_____	Toilet trained	_____
Sat alone	_____	Fed self	_____
Babbled	_____	Rode bicycle	_____
Spoke first words	_____		

Social and Emotional Development:

Please tick if you currently observe any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Difficulty communicating | <input type="checkbox"/> Frequent tantrums |
| <input type="checkbox"/> Prefers to play alone | <input type="checkbox"/> Frequent nightmares |
| <input type="checkbox"/> Does not get along well with peers | <input type="checkbox"/> Difficulties sleeping |
| <input type="checkbox"/> Does not get along well with siblings | <input type="checkbox"/> Eats poorly |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Frequently in trouble |
| <input type="checkbox"/> Is shy or timid | <input type="checkbox"/> Avoids things that cause anxiety |
| <input type="checkbox"/> Is more interested in objects than people | <input type="checkbox"/> Intense interests |
| <input type="checkbox"/> Engages in dangerous behaviours | <input type="checkbox"/> Fixated on gaming or technology |
| <input type="checkbox"/> Has particular fears | <input type="checkbox"/> Poor behaviour if gaming not available |
| <input type="checkbox"/> Soils self or bed | <input type="checkbox"/> Avoids / refuses school |

Education:

What schools or educational facilities has your child attended? Please list all below:

1. Day care _____
2. Kindergarten _____
3. Primary school _____
4. High school _____

Please list any difficulties your child has experienced since commencing their formal education
Eg. Separation anxiety at drop off, learning difficulties, social difficulties.

Has your child been given any additional supports at school. ☐ Y ☐ N If yes, please provide details.

Is your child achieving at the expected level or above on their most recent school report ☐ Y ☐ N

If no, please list what areas they are experiencing difficulty with?

Medical History:

Does your child have any current medical conditions ☐ Yes ☐ No If yes, please provide details.

Does your child take any medications ☐ Yes ☐ No. If yes, please list medications and reasons.

Has your child previously experienced any serious illnesses or injury ☐ Yes ☐ No. If yes, please provide details.

Is there any family history of psychological, developmental or learning disorders ☐ Yes ☐ No. If yes, please provide details.

Treatment History:

Has your child previously consulted a professional for psychological or behavioural problems? ☐ Yes ☐ No. If yes, please provide details.

Has your child previously or currently accessing other allied health treatments Eg. Speech pathology, occupational therapy? ☐ Yes ☐ No. If yes, please provide details.

What treatments have you previously found helpful or unhelpful? Please provide details.

Parenting & Behaviour Management:

What disciplinary measures do you use when your child misbehaves? Please tick all applicable.

- | | |
|--|--|
| <input type="checkbox"/> Ignore problem behaviour | <input type="checkbox"/> Time out |
| <input type="checkbox"/> Scold child | <input type="checkbox"/> Send child to their room |
| <input type="checkbox"/> Threaten child | <input type="checkbox"/> Remove an item such as a toy |
| <input type="checkbox"/> Withdraw access to technology | <input type="checkbox"/> Reason with child |
| <input type="checkbox"/> Redirection | <input type="checkbox"/> Other (Please describe) _____ |

What measures do you use to reward desired behaviour? Please tick all applicable.

- | | |
|---|--|
| <input type="checkbox"/> Praise | <input type="checkbox"/> Rewards Eg. Sticker |
| <input type="checkbox"/> Rewards charts with goal | <input type="checkbox"/> Affection |
| <input type="checkbox"/> Access to technology | <input type="checkbox"/> Food based rewards Eg. Lolly |
| <input type="checkbox"/> Money | <input type="checkbox"/> Other (Please describe) _____ |

Technology:

Please list any devices such as mobile phones, I pods or gaming consoles your child has access to:

How many days per week does your child have access to devices or gaming? _____

How many hours per day does your child average playing on devices or gaming? _____

Do you experience any problems if restrictions are placed on access to devices or gaming? If yes, please provide details: _____

Do you consider that access to devices or gaming causes problems for your child or family? If yes, please provide details: _____

Is there anything else relevant to your child or family circumstances that I should be made aware of?

Thank you for your time