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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
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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:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Age</th>
<th>Behaviour</th>
<th>Age</th>
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</thead>
<tbody>
<tr>
<td>Showed response to parent</td>
<td></td>
<td>Said several words together</td>
<td></td>
</tr>
<tr>
<td>Rolled over</td>
<td></td>
<td>Dressed self</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td></td>
<td>Toilet trained</td>
<td></td>
</tr>
<tr>
<td>Sat alone</td>
<td></td>
<td>Fed self</td>
<td></td>
</tr>
<tr>
<td>Babbled</td>
<td></td>
<td>Rode bicycle</td>
<td></td>
</tr>
<tr>
<td>Spoke first words</td>
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</table>

Social and Emotional Development:

Please tick if you currently observe any of the following:

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

- [ ] Ignore problem behaviour
- [ ] Scold child
- [ ] Threaten child
- [ ] Withdraw access to technology
- [ ] Redirection
- [ ] Time out
- [ ] Send child to their room
- [ ] Remove an item such as a toy
- [ ] Reason with child
- [ ] Other (Please describe) ______________________

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

- [ ] Praise
- [ ] Rewards charts with goal
- [ ] Access to technology
- [ ] Money
- [ ] Rewards Eg. Sticker
- [ ] Affection
- [ ] Food based rewards Eg. Lolly
- [ ] 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