MAUREEN LYONS TASHJIAN, MSW, LCSW

CHILD / ADOLESCENT INTAKE QUESTIONNAIRE

PATIENT INFORMATION: TODAY'S DATE _____

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ HOME PHONE _____

_____ CELL PHONE _____

EMPLOYER/SCHOOL _____ WORK PHONE _____(if applicable)

EMPLOYER ADDRESS _____

_____ POSITION _____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____

RELIGIOUS BACKGROUND _____ HEIGHT _____WEIGHT _____

EDUCATION: (PLEASE CHECK WHICH ONE(s) APPLY)

NURSERY_____YR(s) KINDERGARTEN_____GRADE(s) ELEMENTARY_____GRADE(s)

MIDDLE SCHOOL _____ GRADE(s) HIGH SCHOOL _____ GRADE(s)

DEVELOPMENTAL: (PLEASE INDICATE AT WHAT AGE THIS MILESTONE WAS MET)

ROLLED OVER _____ SMILED _____ LAUGHED _____ CRAWLED _____

PULLED UP _____ WALKED _____ TALKED _____

OTHER MILESTONES NOT LISTED THAT WERE DELAYED? _____

SOCIOLOGICAL INFORMATION: (PLEASE INDICATE IF CHILD IS BIOLOGICAL, ADOPTED, BLENDED ETC.) _____

FATHER'S NAME _____ AGE ____ LIVING ___ DECEASED _____ MOTHER'S NAME _____ AGE ____ LIVING ___ DECEASED _____

OTHER FAMILY MEMBERS:

NAME _____ AGE _____ RELATIONSHIP _____

NAME _____ AGE _____ RELATIONSHIP _____

NAME _____ AGE _____ RELATIONSHIP _____

NAME _____ AGE _____ RELATIONSHIP _____

PLEASE INDICATE WITH WHOM THE CHILD LIVES WITH? and/or IF LIVING ARRANGEMENTS CHANGE.

_____

_____

_____

_____

PSYCHIATRIC HISTORY: Are you aware of any mental illness including (substance abuse history) in your family? If so please indicate who and if possible what their diagnosis is:

_____

_____

_____

Please circle the following highlighted questions and answers

On a scale of 1 to 4 (1 being the most) how safe do you feel at home? **1 2 3 4**

Do you have suicidal thoughts? **NO YES SOMETIMES (PLEASE EXPLAIN)**

_____

_____

_____

Have you ever had thoughts of hurting someone else? **NO YES SOMETIMES (PLEASE EXPLAIN)**

_____

_____

_____

PATIENT REFERRED BY: _____

PLEASE NOTE DUE TO THE EVER CHANGING LEGAL ENVIRONMENT WE FIND OURSELVES IN THIS OFFICE DOES NOT SEE MINORS WITHOUT THE CONSENT OF BOTH PARENTS. IF YOU HAVE SHARED CUSTODY OF YOUR CHILD IT IS YOUR RESPONSIBILY TO OBTAIN PERMISSION IN ORDER FOR YOUR CHILD TO RECEIVE TREATMENT FROM THIS OFFICE. (SEE RELEASE FORMS) PARENTS/GUARDIANS PLEASE BE AWARE THAT CONFIDENCIALITY APPLYS TO THE CHILD AND ANYTHING SAID IN SESSION BY A PARENT MUST BE TREATED AS ADJUNCT THERAPY. IF YOU HAVE ANY QUESTIONS PLEASE DISCUSS THIS WITH YOUR CHILD'S THERAPIST. IT IS YOUR RESPONSIBILY TO CONTACT ANY AND ALL PARTIES WHO SHARE IN YOUR CHILD'S MEDICAL DECISIONS. THIS OFFICE MUST HAVE A LIST OF ALL PARTIES INVOLVED IN THE CARE OF YOUR CHILD PERSUARTED TO APPLICABLE COURT ORDERS AND WOULD BE HAPPY TO COMMUNICATE WITH ALL PARTIES INVOLVED DURING REGULAR BUSINESS HOURS.

DO NOT COMPLETE, TO BE COMPLETED WITH THERAPIST:

HAVE YOU EVER SMOKED?

_____

HAVE YOU EVER DRANK?

_____

HAVE YOU EVER HAD SEX?

_____

HAVE YOU EXPERIMENTED WITH DRUGS?

_____

TRIED OR CONSIDERED TRYING TO COMMIT SUICIDE?

_____

DO YOU LIKE SCHOOL?

_____

DO YOU HAVE FRIENDS?

_____

WHO IS THE ONE ADULT YOU COULD TRUST IF YOU FOUND YOURSELF IN TROUBLE?