Audra York Therapy, LLC
Audra York, LPC, MFT

4325 Laurel Street #230A Phone: (907) 952-8532
Anchorage, AK 99508

Child Intake Questionnaire

Date:_____

Person completing this form:_____

Relationship to client: _____

Last Name:_____ First Name:_____ MI:_____

Nickname:_____

Date of Birth:_____ SS #:_____

Gender: Male Female

Referred By:_____

Ethnic/Cultural Origins:_____

Parent(s)/ Guardian Name:_____

Allergies:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Mailing Address (if different from home):_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Carrier:_____

Work Phone:_____ Other:_____

Email Address:_____

Emergency Contact:_____ Ph:_____

Relationship:_____

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Insurance Information

Primary Insurance:_____

Insurance Phone:_____

Insurance ID Number:_____

Insurance Group Number:_____

Effective Date:_____

Client's relationship to Insured:_____

Insured Name- Last:_____, First:_____, MI:____

Insured Street Address:_____

Insured City, State, Zip Code:_____

Insured Phone Number:_____

Insured Date of Birth:_____

Insured's Gender: Female Male

Insured's Employer:_____

Secondary Insurance:_____

Secondary Authorization Number:_____

Insured Name- Last:_____, First:_____, MI:____

Client's relationship to Insured:_____

Insured Date of Birth:_____

Insurance ID Number:_____

Insurance Group Number:_____

Effective Date:_____

Insured's Employer:_____

Insured Street Address:_____

Insured City, State, Zip Code:_____

Insured Phone Number:_____

Insured's Gender: Female Male

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Who currently lives with the child? (use additional paper if needed)

Names Date of Birth Relationship

_____

_____

_____

_____

_____

_____

Other people who have regular contact with child: (e.g boyfriend/girlfriend, aunt/uncle, neighbor, etc.)

Names Date of Birth Relationship

_____

_____

_____

_____

_____

Name of child's biological father:_____ Date of Birth:_____

Occupation/Place of Employment:_____

Name of child's biological mother:_____ Date of Birth:_____

Occupation/Place of Employment:_____

Siblings: (use additional paper if needed)

Name Date of Birth Biological, Step, Half

_____

_____

_____

_____

_____

How many moves has this child had? 1-2 3-4 5 or more

Does your child have an OCS or Probation Officer? _____

If yes, their name:_____

Who has legal custody of this child? _____

Their contact information:_____

Is there shared custody of this child? Yes No

Please describe any legal or court proceedings the child is involved in, including criminal and custody:

_____

_____

_____

Who is the primary caregiver for this child? _____

Health History

Does the child have a medical provider? Yes No

If yes, who do they see? _____

Date of last physical exam:_____

Any medical concerns or disabilities? Yes No

If yes, please describe: _____

_____

Medications child is currently taking: _____

_____

Has the child had previous counseling, including residential treatment? Yes No

Does the child have a history of self-harm or suicide? Yes No

If yes, when was the last incident? _____

Is there a family history of self-harm or suicide? Yes No

Is there a family history of mental illness or developmental delays? Yes No

If yes, please list relationships to child and illness and/or delays:

_____

_____

_____

Has the child seen alcohol or illegal/ prescription drug use? If yes, please describe:

_____

_____

Has the child been given or used substance or alcohol use/abuse? Yes No

If yes, please describe: _____

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Is there a family history of substance or alcohol use/abuse? Yes No

If yes, please describe: _____

_____

Education and Social History

Name of School:_____ Grade:_____

Child is doing: Well Average Poorly

Does the child receive Special Education or have an IEP? _____

Is there a history of referrals, detentions or suspensions? Yes No

If yes, please describe:_____

_____

Please list any other academic and/or behavior problems the child has in school:

_____

_____

Please list any activities or programs that the child is involved in:

_____

_____

Does the child make friends easily? _____

Any concerns with social connections or behaviors?

_____

_____

Developmental History

Was the pregnancy planned? Yes No

Did child's mother use substances or alcohol during pregnancy? Yes No

Please list any complications or concerns during pregnancy or delivery:

_____

_____

Age child talked:_____ Age child walked :_____ Age child potty trained: _____

Did child meet developmental milestones? Yes No

Any developmental concerns? _____

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How many caregivers did the child have during infancy/toddler years? 1-2 3-4 5 or more

Describe any attachment concerns:_____

_____

_____

Trauma History

Have there been any prior concerns of physical abuse, sexual abuse and/or neglect to this child or siblings? Yes No

If yes, please give dates and briefly describe: _____

_____

_____

Has the child witnessed violence or fighting? Yes No

If yes, please provide some information: _____

_____

_____

Please list other possible traumas (e.g. car accidents, grief and loss, etc.):

_____

_____

Has this child seen adults hit one another? Yes No

If yes, please describe: _____

To your knowledge, has anyone in the immediate family ever been sexually abused? Yes No

If yes, please provide some information: _____

_____

_____

To your knowledge, has anyone in the immediate family ever been physically abused? Yes No

If yes, please provide some information: _____

_____

_____

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Brief Checklist

Does this child have any of the following behaviors?

	Often	Occasionally	Never
Sleep problems: nightmares, insomnia, sleepwalking	☐	☐	☐
Fear of people, places, animals, situations	☐	☐	☐
Sense of fearlessness	☐	☐	☐
Aggressiveness, hitting, bullying	☐	☐	☐
Destroying property, fire setting	☐	☐	☐
Sexualized play, behavior, language, masturbation	☐	☐	☐
Inappropriateness with other people's private or social spaces	☐	☐	☐
Withdrawal, Isolating self	☐	☐	☐
Lying	☐	☐	☐
Making up things, but not knowing it isn't true	☐	☐	☐
Stealing or taking things	☐	☐	☐
Anger, tantrums, foul language, cruelty to animals	☐	☐	☐
Sadness, tearfulness, clinginess	☐	☐	☐
Nervous habits: nail biting, picking skin, etc.	☐	☐	☐
Pulling at hair or eyelashes	☐	☐	☐
Eating disorders: overeating, refusing to eat, vomiting, hoarding food	☐	☐	☐
Mood changes	☐	☐	☐
School problems	☐	☐	☐
Truancy (skipping school)	☐	☐	☐
Problems changing activities, places or things (resistant to change)	☐	☐	☐
Stares into space or seems preoccupied	☐	☐	☐
Gang affiliation	☐	☐	☐
Self-mutilation: cutting, marking, picking at skin, biting self	☐	☐	☐
Suicide attempts	☐	☐	☐
Talking about or trying to harm self or others	☐	☐	☐

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Therapeutic Services

Briefly describe the reason for which this child is seeking therapeutic services:

_____

_____

What are your thoughts of this child's current struggle? Please describe briefly:

_____

_____

_____

Briefly describe how this child's behavior affects the family, school performance or social interactions:

_____

_____

_____

What are you hoping this child will gain from therapy?

_____

_____

_____

What are you hoping the family will gain from therapy?

_____

_____

_____

What strengths does this child have?

_____

_____

Are you interested in medication for this child? Yes No

Any other comments or concerns? _____

_____

_____