FREE TO FEEL THERAPEUTIC SERVICES, PLLC

MINOR INTAKE QUESTIONNAIRE

Note: This form is lengthy. Please know that all questions will help us better understand your child and family and are useful as we try to address concerns and make recommendations. If you require assistance completing this form, please let us know.

Date: _____
Form Complete By: _____ **Relationship: _____**

A. PERSONAL IDENTITY

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

B. Referral Information

Who referred you today? _____
What are your main concerns for your child? _____
_____
What does the child know about this referral or therapy? _____
_____

C: Family and Living Situation

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 your family:

- ☐ Rent apartment
- ☐ Rent home
- ☐ Own home
- ☐ Reside with friends/family
- ☐ Currently unhoused

Please describe the child's relationship with parents, siblings, and other significant family members (note any significant changes):

_____
_____
_____
_____
_____

Please note any family history (maternal and paternal) of health concerns:

Physical health: _____
_____
Mental health: _____
_____
Chemical health: _____
_____

D. Developmental and Health History

Please note any complications with pregnancy, labor, delivery, or health immediately after birth (for both mother and child) including post-partum mental health concerns: _____
_____
_____
_____

Please describe any concerns for developmental milestones (walking, talking, toileting, etc.):

_____
_____
_____

Please note any services and providers your child received between 0-6 years (i.e speech, occupational therapy, physical therapy, mental health, etc.):

_____
_____
_____

Does your child have a history of any of the following concerns (please describe including ages and whether concerns are current or resolved):

- ☐ Allergies_____
- ☐ Asthma _____
- ☐ Surgery _____
- ☐ Head Injury _____
- ☐ Hospitalization _____
- ☐ Other Chronic Condition: _____
- ☐ Vision Concerns: _____
- ☐ Hearing Concerns: _____

Please list any medications including dosages, condition being treated, and prescribing physician:

_____
_____
_____

Sleep concerns (current and previous):

- ☐ Longtime to fall asleep _____
- ☐ Night waking_____
- ☐ Nightmares_____
- ☐ Bedwetting_____
- ☐ Sleep changes_____
- ☐ Other_____

Appetite/eating concerns (current and previous):

- ☐ Excessively picky _____
- ☐ No appetite_____
- ☐ Binge eating_____
- ☐ Restrictive eating_____
- ☐ Appetite changes_____
- ☐ Other_____

E. Mental Health and Substance Use History

Please describe any mental health services received, approximate dates, and providers: (Includes evaluations, hospitalizations, residential care, intensive programs, therapy, etc.)

_____
_____
_____

Please describe any concerns for substance use by the child (tobacco, alcohol, drugs, etc.):

_____

_____

_____

Please describe any exposure to substances through peers, family, etc. (tobacco, alcohol, drugs, etc.):

_____

_____

_____

F. Stressors/Trauma History and Safety Concerns

Has the child experienced/witnessed any of the following:

- ☐ Car accident
- ☐ Natural Disaster
- ☐ Significant illness (own)
- ☐ Significant illness (other)
- ☐ Death of a love one
- ☐ Homelessness
- ☐ Emotional Abuse
- ☐ Physical abuse
- ☐ Neglect
- ☐ Sexual abuse
- ☐ Sex Trafficking
- ☐ Domestic violence
- ☐ Community violence
- ☐ Racial trauma/violence
- ☐ Bullying
- ☐ Significant parental conflict
- ☐ Incarceration (own)
- ☐ Incarceration (other)
- ☐ Witnessed violence act
- ☐ Animal incident (bite, aggression, etc.)
- ☐ Other

Please describe each incident including the child's age, whether the child was a witness or participant, and potential impact on the child:

_____

_____

_____

_____

_____

_____

Please note and describe any current safety concerns:

- ☐ Suicidality _____
- ☐ Self-Injury _____
- ☐ Aggressive _____
- ☐ Running away _____
- ☐ Impulsivity _____
- ☐ Other _____

Please note any safety plans or agreements currently in place (OFPs, mental health safety plans, etc.)

_____
_____
_____

G. School and Employment

Current School: _____ Grade: _____

Please describe any current or previous concerns with child's academic functioning:_____

_____
_____
_____

Please describe any current or previous concerns for the child's behavioral functioning:

_____
_____
_____

Is the child currently or were they previously on any type of educational plan?

- ☐ Current IEP (category if known _____)
- ☐ Previous IEP (category if known _____)
- ☐ Current 504 (category if known _____)
- ☐ Previous IEP (category if known _____)

Please note any current or previous employment for the child (i.e. type of employment, hours per week, etc.):

_____
_____

H. Behavioral/Emotional Concerns

Behavior	What does it look like?	How often does it occur? How long does it last?	When did this behavior start?
[ ] Worries			
[ ] Repetitive Questions			
[ ] Reassurance Seeking			
[ ] Reactivity (big reactions to small situations)			
[ ] Mood Swings			
[ ] Irritability			
[ ] Tantrums			
[ ] Withdrawal			
[ ] Difficulty Seeking Help			
[ ] Difficulty Accepting Help			
[ ] Difficulty Coping with Change			
[ ] Fatigue/Low Energy			

[ ] Hyperactivity			
[ ] Impulsivity			
[ ] Inattention/Easily Distracted			
[ ] Hypervigilance			
[ ] Task Avoidance			
[ ] Self-Esteem Concerns			
[ ] Aggression			
[ ] Somatic complaints (eg. stomach or head aches)			
[ ] Other (describe)			

Please note and describe any of the following COMMUNICATION concerns:

- Taking things too literally _____
- Difficulty initiating conversation _____
- Repeating words or phrases _____
- Using language that would be more common in much older or younger children _____
  _____
- Difficulty maintaining conversation _____

- ☐ Difficulty staying on topic _____
- ☐ Blurting/interrupting _____
- ☐ Difficulty talking about feelings _____
- ☐ Only talking about certain topics _____
- ☐ Other _____

Please note and describe any difficulty with current or previous PLAY skills:

- ☐ Little interest in toys _____
- ☐ Using toys in strange ways _____
- ☐ Difficulty playing by themself _____
- ☐ Difficulty playing quietly _____
- ☐ Lining up or organizing toys _____
- ☐ Little imaginary play _____
- ☐ Difficulty accepting others' ideas within play _____
- ☐ Only wanting to play with certain toys or around certain ideas/themes _____
  _____

Please describe any current or previous SOCIAL concerns:

- ☐ Difficulty initiating peer contact _____
- ☐ Difficulty sustaining friendships_____
- ☐ Difficulty making friends_____
- ☐ Controlling in play _____
- ☐ Difficulty functioning in groups _____
- ☐ Choosing friends who are mean or take advantage of the child_____
  _____
- ☐ Fixation on 1-2 friends _____
- ☐ Limited social interest _____

Please note any significant changes to your child's social skills, abilities, peer group, etc. within the last 6-12 months: _____
_____

Please describe any of the following SENSORY concerns:

- ☐ 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 any difficulties your child has in independently meeting their self-care needs (toileting, showering/bathing, brushing teeth and hair, changing clothes, chores, etc.):

_____
_____
_____

I. Strengths, Resources, and Basic Needs

What do you see as your child's greatest strengths(s): _____
_____
_____

What does your child see as their greatest strength(s): _____
_____
_____

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 _____

Please note any areas in which you feel like you struggle to provide for the child's basic needs:

- ☐ Clothing
- ☐ Food
- ☐ Shelter
- ☐ Education
- ☐ Medical Care
- ☐ Transportation
- ☐ Enrichment activities/social opportunities

What services do you feel would be helpful for your child and family at this time:

_____
_____