



SAMARITAN COUNSELING & GROWTH CENTER
245 SE MADISON BLVD.
BARTLESVILLE, OK 74006
(918) 336-1463

CHILD-TEEN INTAKE QUESTIONNAIRE

DATE _____

Confidential and Privileged Information

Answer all questions as well as you can. Your completion of this questionnaire will help decrease the time needed to make an accurate evaluation of your child/teen's difficulties, as well as help to focus attention to your most relevant concerns. If you do not understand any of the questions, please feel free to discuss them with our staff or your counselor.

Identifying Information:

Child/Teen's Name: First _____ MI _____ Last _____

Gender: (Select One) Male Female Age _____ DOB _____

Ethnicity: (Select One) White/Caucasian African American Native American
Hispanic Asian Other: _____

Address, City, State, Zip: _____

Telephone, with area code, Home: _____ Cell: _____ Emergency: _____

Preferred Method for Courtesy Appointment Reminders:

Do not remind me Call to Home Phone Call to Mobile Phone Call to Work Phone

You are responsible for appointments you schedule whether you receive a courtesy call or not.

Emergency Contact: _____ **Phone:** _____

Who has legal custody of this child/teen? _____

Child/teen's physician or clinic: _____

Mother's name: _____ **DOB:** _____

Address, City, State, Zip: _____ **Phone:** _____

Father's name: _____ **DOB:** _____

Address, City, State, Zip: _____ **Phone:** _____

Payment Information:

Party responsible for payment: _____

Address: _____

Is child/teen covered by insurance: Yes No **If Yes, Insurance Company:** _____

Insured's name: _____ **SSN:** _____

Insured's ID #: _____

Insured's address: _____

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Having read and completed the Personal History form, I hereby declare that the information I have given is correct and complete, to the best of my ability.

Signature of Responsible Party _____ **Date** _____ **PHI**

Client Name: _____

Family Information:

Is this child/teen adopted Yes No If yes, when? _____
Are parents separated? Yes No If yes, when? _____
Are parents divorced? Yes No If yes, when? _____
Is/are there step-parents? Yes No

(If there are other adults, such as previous step-parents, who have been involved in the child/teen's life, you may include their names on the final page of this questionnaire.)

Step-Parents' or Legal Guardian Names: _____

Siblings: (List all full, half, or step brothers and sisters of client, living or dead, in order of birth.)

	<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relation to client</u>	<u>Living with client</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Please provide name and relationship to the client of anyone else living in the home currently.

Family History of Medical and/or Emotional Difficulties:

Describe any major medical/emotional problems in family member(s) :

History of the Current Problem:

What is the problem(s) that brings your child/teen to Samaritan?

At what age was the child/teen's problems first noted? _____

Please describe any illness or injury that may have been associated with the problem

Has your child/teen even had counseling for this problem? (Select one) Yes No
If yes, where? _____ When? _____
Has your child/teen had any counseling for any other problems? (Select one) Yes No
If yes, where? _____ When? _____
Are there other members of the family with a similar problem? (Select one) Yes No

Client Name: _____

Medical History of Child/Teen:

Describe any serious accident, illness or injury which your child/teen has had and at what age?

Please list any medications your child/teen is presently taking?

- 1. _____ Dosage _____ Frequency _____
- 2. _____ Dosage _____ Frequency _____
- 3. _____ Dosage _____ Frequency _____

Educational History:

Attends(ed) pre school? Yes No

Attends(ed) kindergarten? Yes No

In special classes? Yes No List: _____

Ever been suspended? Yes No

School currently attending: _____ Grade: _____

Any current school problems? Describe

Spiritual/Religious

How important to your child are spiritual or religious matters? Not Little Some Much

Are you affiliated with a spiritual or church group? Yes No Name: _____

Would you like your spiritual/religious belief incorporated into your counseling? Yes No

Strengths and Assets of the Child/Teen and Family:

What are your child/teen's strengths?

What are your family's strengths?

Client Name: _____

Please tell us anything else you think will be of help in our wanting to understand your child/teen. Include any questions that you would like us to answer. If you need additional room please add your own page.



Thank you for taking the time to complete this questionnaire.

Having read and completed the Personal History form, I hereby declare that the information I have given is correct and complete, to the best of my ability.

Signature of Responsible Party _____ Date _____

Relationship to Client: _____