Pediatric Intake Questionnaire

PERSONAL HISTORY

Childs Name		Date of Birth/Age	

Address		Gender	
State, Zip Code		Pediatrician	

Parent(s) / Guardian(s) Name	DOB:

Home Phone:		May we leave voicemail	☐ Yes ☐ No
Cell Phone:		May we leave voicemail	☐ Yes ☐ No

Emergency Contact		Phone Number:	
Relationship to Child		Cell Number:	

MEDICAL HISTORY

Field	
Reason for Referral **(Brief Description)**	
Medical Diagnoses and Hospitalizations	
Medications **(including over the counter)**	
Precautions or Allergies	
Additional Comments (things we should know)	

SOCIAL HISTORY

Childs School Attended / Grade	
Siblings / Ages	

Has child had therapy before	
If “yes”, when? where?	
If “yes”, why?	

What are your child's interests?	

What are your child’s fears or anxieties?	

Additional Comments (things we should know)	

BEHAVIOR PROFILE

Aggressive towards self?	☐ Yes ☐ No	Aggressive towards others?	☐ Yes ☐ No
Bites self or others?	☐ Yes ☐ No	Destructive with belongings?	☐ Yes ☐ No
Vocal tics?	☐ Yes ☐ No	Motor tics?	☐ Yes ☐ No
Avoids social interactions?	☐ Yes ☐ No	Easily frustrated?	☐ Yes ☐ No
Does your child “bolt”?	☐ Yes ☐ No	Aware when they hurt others?	☐ Yes ☐ No

INSURANCE INFORMATION

Insurance Provider		Group Number
Policy Holder / Name		Policy Number