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: Male Female Age ______________ DOB ______________ SSN_____ - ______ - ________

Ethnicity: White/Caucasian African American Native American

Hispanic Asian Other: ________________

Household Income: $0-$9,999 $10,000-$14,999 $15,000-$19,999 $20,000-$24,999

$25,000-$49,999 $50,000 or more Confidential

Address, City, State, Zip: ____

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

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

Were you referred to our office? ________________ If yes, by whom? _________________________

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 DOB: _______________________ 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 ________________________

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.)

	Name	Age	Sex	Relation to client	Living with client
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) :______________________________

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History of the Current Problem:

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

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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 ever had counseling for this problem? Yes No

If yes, where? ______________________________When? ____________________

Has your child/teen had any counseling for any other problems? Yes No

If yes, where? ______________________________When? ____________________

Are there other members of the family with a similar problem? 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?

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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? ____

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What are your family's strengths? ____

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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.

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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: ____