Name: _____

FREMONT COUNSELING SERVICE
Child/Youth Intake – Additional Questions

Child's Name: _____ Age: _____ Date: _____

All responses to these questions are kept strictly confidential.

CUSTODIAL STATUS

Who has legal custody of the child? _____

Who has parental rights of the child?
Mother ☐ Yes ☐ No Father ☐ Yes ☐ No

Who has physical custody of the child? _____

DEVELOPMENTAL HISTORY

Were there complications with this pregnancy? ☐ Yes ☐ No ☐ Unknown
Did the mother sustain any major illness/injury while pregnant? ☐ Yes ☐ No ☐ Unknown

During the pregnancy, did the mother use:

Tobacco?	☐ Yes	☐ No	☐ Unknown
Alcohol?	☐ Yes	☐ No	☐ Unknown
Prescription drugs?	☐ Yes	☐ No	☐ Unknown
Other substances?	☐ Yes	☐ No	☐ Unknown

Was delivery: ☐ Early ☐ Normal ☐ Late ☐ Unknown
Were there any complications with/labor delivery? ☐ Yes ☐ No ☐ Unknown

Was the infant? / Is the child?

Not easy to comfort?	☐ Yes	☐ No	☐ Unknown
Quiet?	☐ Yes	☐ No	☐ Unknown
Excessively irritable?	☐ Yes	☐ No	☐ Unknown
Prone to temper tantrums?	☐ Yes	☐ No	☐ Unknown
Quick to anger?	☐ Yes	☐ No	☐ Unknown
An excessive climber?	☐ Yes	☐ No	☐ Unknown
Resistant to physical contact?	☐ Yes	☐ No	☐ Unknown
Sleep too much / too little?	☐ Yes	☐ No	☐ Unknown
Eat too much / too little?	☐ Yes	☐ No	☐ Unknown
Eat things that were not food?	☐ Yes	☐ No	☐ Unknown

Developmental Milestones:

Gross motor?	☐ Early	☐ Average	☐ Delayed	☐ Unknown
Fine motor?	☐ Early	☐ Average	☐ Delayed	☐ Unknown
Social skills?	☐ Early	☐ Average	☐ Delayed	☐ Unknown

Speech functioning?	☐ Normal	☐ Some Problems	☐ Requires Assistance	☐ Should be Evaluated
Hearing functioning?	☐ Normal	☐ Some Problems	☐ Requires Assistance	☐ Should be Evaluated
Visual functioning?	☐ Normal	☐ Some Problems	☐ Requires Assistance	☐ Should be Evaluated

Are the child's immunizations up to date? ☐ Yes ☐ No ☐ Unknown

Is the child able to form and maintain relationships? ☐ Yes ☐ No ☐ Unknown

Name: _____

Is the child's housing situation stable? ☐ Yes ☐ No ☐ Unknown

Is the child at risk for an out-of-home placement? ☐ Yes ☐ No ☐ Unknown

Current school, grade, teacher OR current day/childcare situation:

_____

_____

Does the child have an IEP or MDT in place? ☐ Yes ☐ No ☐ Unknown

Does the child have behavior problems at school / daycare? ☐ Yes ☐ No ☐ Unknown

Has the child had any educational evaluations? ☐ Yes ☐ No ☐ Unknown

How does the child's intellectual functioning appear? ☐ Below Average ☐ Average ☐ Above Average

PARENT/GUARDIAN INVOLVEMENT

Is the child's parent/guardian able and willing to participate in the child's services as indicated? ☐ Yes ☐ No

Please describe any special areas of interest, hobbies of the parent/guardian, or other things that they enjoy doing: _____

_____

_____

Do you have any needs or preferences for the treatment/services that your child receives? (For example: Male or female clinician? How often would you like your child to be seen? Day/afternoon/evening appointments?)

_____

_____

_____

What is your goal for treatment of your child? What do you hope to accomplish by your child receiving services from us?

_____

_____

_____

_____

Signature Date

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FOR OFFICE USE ONLY:

_____

_____

_____

_____

_____

_____

Intake Clinician Signature Date

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SCANNED: _____ ATTACHED TO FILE: _____

Date / By Date / By

OFFICE USE ONLY: Clinician has entered notes on section in AZ? Yes No