

General Intake Questionnaire for Child
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Name: _____ Date: _____

What are the primary concerns that led you to seek counseling for your child?

What have you already tried to alleviate this problem? _____

Medical factors

List any medical problems he/she has _____

Medications

Is your child taking any prescribed medications? no yes

Name of doctor prescribing _____

Name of medication	dose	date began	refill date
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Substance abuse

Does your child have any history of alcohol or substance abuse? _____

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