

## Parent Intake Questionnaire – Online Version

KU Child and Family Services Clinic  
1000 Sunnyside Avenue • Lawrence, KS • 66044  
Phone: (785) 864-4416

Date: \_\_\_/\_\_\_/\_\_\_ Form completed by: \_\_\_\_\_  
(name) (relation to child)

### Child Information

Name: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Ethnicity/Race: \_\_\_\_\_ Sex: Male  Female

Primary Address: \_\_\_\_\_  
(street) (city) (state) (zip code)

Primary Physician: \_\_\_\_\_

### Family Information

Parent/Caregiver 1: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
(street) (city) (state) (zip code)

Occupation: \_\_\_\_\_ Place of work: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Caregiver 2: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
(street) (city) (state) (zip code)

Occupation: \_\_\_\_\_ Place of work: \_\_\_\_\_ Phone: \_\_\_\_\_

Where/with whom does the child live? Please check all that apply.

- Birth parent(s)
- Adoptive parent(s)
- Foster parent(s)
- Other relatives (please specify): \_\_\_\_\_
- Shared custody arrangement (please explain): \_\_\_\_\_
- Other (please explain): \_\_\_\_\_

### **FOR OFFICE USE ONLY – Please do not write in this area.**

*Reminder to clinic associates: Address questions not listed on online version of form.*

**Please list other individuals who live with the child (e.g. siblings, other relatives):**

<i>Adults</i>		<i>Children</i>	
Name	Relation to child	Name	Relation to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Developmental and Medical Information**

**Were there any pregnancy and/or birth complications with this child?** No  Yes

If “yes”, please explain: \_\_\_\_\_

**At what age did your child first:**

Sit without support \_\_\_\_\_ Use phrases or sentences \_\_\_\_\_ Spell name \_\_\_\_\_  
 Walk without help \_\_\_\_\_ Play make-believe \_\_\_\_\_ Use toilet \_\_\_\_\_  
 Use single words \_\_\_\_\_ Count to 10 \_\_\_\_\_ Stay dry though the night \_\_\_\_\_

**Has your child had any chronic medical issues or developmental delays?** No  Yes

If “yes”, please explain: \_\_\_\_\_

**Family and Personal Health History**

**Please check the condition and relationship of any relative who has or has had any of the conditions listed below.**

<b>Check condition and relationship of any relative who has or has had any of the conditions listed below.</b>	Child Being Seen	Father	Paternal Grandfather	Paternal Grandmother	Paternal Aunt/Uncle	Mother	Maternal Grandfather	Maternal Grandmother	Maternal Aunt/Uncle	Siblings	Other _____
Attention-Deficit/Hyperactivity Disorder											
Autism Spectrum Disorder											
Alcoholism											
Anxiety											
Bipolar Disorder											
Cancer											
Depression											
Diabetes											
Heart disease/heart attack											
Learning disorder											
Schizophrenia											
Substance abuse/dependence											

**School Information**

Where does your child attend school? \_\_\_\_\_ Grade level: \_\_\_\_\_

Does your child receive additional educational supports (e.g. IEP)? No  Yes

If “yes”, please explain: \_\_\_\_\_

Does your child have any behavior, social, or learning problems in school? No  Yes

If “yes”, please explain: \_\_\_\_\_

What other schools has your child attended? Please list all, and briefly note any problems.

Grade(s)	School	Behavioral/Social/Learning Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Parental Concerns**

In your opinion, what is your child’s main problem? That is, why are you seeking services?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What have you been told by doctors, therapists, teachers, or others about your child’s problems?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you hope to gain through treatment and/or assessment services? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like to add about your reasons for seeking services or your goals for services? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Thank you for taking the time to complete this intake questionnaire!*