Parent Intake Questionnaire

KU Child and Family Services Clinic

Date: ____/____/____ Parent/Caregiver Name: _____

What is your relationship to the child?_____

Child Information

Name: _____ **Date of birth:** ____/____/____

(first, last)

Ethnicity/Race (please check all that apply):

- ☐ African-American/Black/African Origin
- ☐ American Indian/Alaska Native/Aboriginal Canadian
- ☐ Asian-American/Asian Origin/Pacific Islander
- ☐ Latino-a/Latinx/Hispanic
- ☐ White/European Origin
- ☐ Bi-racial/Multi-racial
- ☐ Other

Sex Assigned at Birth: _____

Gender: _____

Pronouns:

- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/their
- ☐ Other

Primary Address: _____

(street) (city) (state) (zip code)

Health Insurance: _____

Primary Physician: _____

Family Information

Parent/Caregiver 1: _____ **Date of birth:**___/___/___

Gender: _____

Pronouns:

- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/their
- ☐ Other

Address *(if different from above)*:_____

(street) (city) (state) (zip code)

Phone: _____ **Occupation:** _____ **Place of work:** _____

Parent/Caregiver 2: _____ **Date of birth:** ___/___/___

Gender: _____ **Pronouns:**

- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/their
- ☐ Other

Address *(if different from above)*:_____

(street) (city) (state) (zip)

Phone: _____ **Occupation:** _____ **Place of work:** _____

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

- ☐ Birth parent(s)
- ☐ Adoptive parent(s)
- ☐ Foster parent(s)
- ☐ Other (please explain): _____

If child lives with other relatives, please specify: _____

If shared custody arrangement, please explain: _____

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

Adults		*Children*	
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 ____	Crawl ____	Walk ____
Count to 10 ____	Spell name ____	Use single words ____
Use phrases or sentences ____	Play make-believe ____	Use toilet ____
Stay dry though the night ____		

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

If "yes", please explain: _____

_____

Is your child currently taking any medication? **No ☐** **Yes ☐**

Name of medication	Condition being treated	Dosage

If additional medications please list Medication/Condition being treated/Dosage below:

_____

_____

_____

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.

	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											
Other: _____											

School Information

Where does your child attend school? _____ **Grade level:** _____

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

If "yes", what is included in the IEP? _____

_____

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? _____

_____

Please let us know if you have any accessibility needs so that we may accommodate these to the best of our ability. Your clinician may contact you prior to your first session to gather more information about what accommodations we can provide. Please list any accessibility needs here:_____

_____

_____