TheWellnessCentre

Client Information

Please print clearly

Client Name: _____
Last First MI

Client Date of Birth: _____/_____/_____ Age: _____
DD / MM / YYYY

Parent(s)/Guardian(s) if client is a minor: _____

_____

Physical Address: _____ District: _____

Mailing Address: _____ KY____- _____

For Phone & Email information, please tick box for Preferred Method of Contact

Phone: ☐_____ ☐_____ ☐_____
Home Work Cell

Email 1: ☐_____

Email 2: ☐_____

Current School if client is a minor: _____Grade/Year: _____

Current Employer (Client/Guarantor): _____

Employer Address: _____ Employer Phone: _____

Payment Preference: ☐Self-Pay ☐Insurance ☐Corporate Partner_____ ☐Other_____

Insurance Assignment

Insurance Company: _____
(Please provide copy of both sides of insurance card & fill out and sign Insurance Claim Form in this pack.)

Policy Holder: _____Insurance ID Number: _____

I, _____ (print name) do hereby give full permission and authorize The Wellness Centre to bill my health insurance company for services rendered by The Wellness Centre.

_____ _____/_____/_____
Signature DD / MM / YYYY

D4 Cayman Business Park, GT
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(345) 949-9355 / Email: info@wellnesscentre.ky
www.wellnesscentre.ky

CONFIDENTIAL
CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

This questionnaire is to be completed by the child's parent or legal guardian. This form has been designed to provide essential information in order to help us in understanding your child. All information provided by you is strictly confidential and will only be released with your written consent. The Release of Information & Parental/Guardian Consent form is included at the end of this document.

PLEASE PRINT
Name of Person Completing this form: _____
Relationship to child or adolescent: _____

Child or Adolescent Information:
Legal Name of Child/Adolescent: _____
Nickname or name child routinely goes by: _____
Child's Date of Birth: _____ Age: _____ Gender: _____
Place of Birth: _____ Child's Nationality: _____
Immigration Status: _____

Child's Home Address:
P.O. Box _____ Postal Code: _____ Phone: _____
Street Address: _____ District_____
With whom does the child live? _____

Emergency Contact:
Name: _____ Phone: _____
Relationship: _____

Referral Information:
What is the reason for the referral? _____
_____
_____

Parent/ Guardian 1: Name_____
Relationship to child: _____
Date of Birth: _____ Gender: _____ Age: _____ Nationality: _____
Place of Birth: _____ Immigration Status: _____
P.O. Box: _____ Postal Code: _____ Street Address: _____
Country of Residence: _____ City or District: _____

May we contact you by (check all that apply):

- □ Email: _____
- □ Home phone: _____ Leave a message? **Y/N**
- □ Work phone: _____ Leave a message? **Y/N**
- □ Cell phone: _____ Leave a message? **Y/N**

Occupation: _____ Employer: _____
Education Completed: _____
Physical Health: ____ Excellent ____ Good ____ Fair ____ Poor

Parent/ Guardian 2 Name_____
Relationship to child: _____
Date of Birth: _____ Gender: _____ Age: _____ Nationality: _____
Place of Birth: _____ Immigration Status: _____
P.O. Box: _____ Postal Code: _____ Street Address: _____
Country of Residence: _____ City or District: _____

May we contact you by (check all that apply):

- □ Email: _____
- □ Home phone: _____ Leave a message? **Y/N**
- □ Work phone: _____ Leave a message? **Y/N**
- □ Cell phone: _____ Leave a message? **Y/N**

Occupation: _____ Employer: _____
Education Completed: _____
Physical Health: ____ Excellent ____ Good ____ Fair ____ Poor

Does either parent's job require him/her to be away from home long hours or extended periods?
_____

Marital Status of parents:
□Married □Divorced □Separated □Widowed □Single □Cohabitants
If married, how long have you been married? _____
If divorced, how long have the biological parents been divorced? _____

If parents are not married, who has legal custody of the child? _____
Is it full custody or joint? _____
Please explain:_____

Has either parent been married before or since? □Mother □Father

If yes, please provide dates of previous marriage(s), names, and ages of children from these marriages:
Mother: _____ Children & Ages: _____
Father: _____ Children & Ages: _____

Please list the names of the stepparents: _____

Is there a birth parent living outside the home: (circle one) MOTHER/FATHER
Name: _____ Where do they live? _____

If the birth parent(s) do not live in the child's home, how much contact does the child have with the parent not having custody, with stepsiblings, etc.?
_____
_____

Siblings:

	Name	Age	Relationship	Living in Home?	School	Grade
1.	_____	_____	_____	**Y / N**	_____	_____
2.	_____	_____	_____	**Y / N**	_____	_____
3.	_____	_____	_____	**Y / N**	_____	_____
4.	_____	_____	_____	**Y / N**	_____	_____

Please indicate any special needs or concerns regarding the other children living in your home:
_____
_____

Please indicate any concerns you have regarding the child for whom you are seeking services and these sibling relationship(s):
_____
_____

Others:
List any other people who currently, or in the child's lifetime, have lived in your home.

	Name	Age	Relationship to Child	Years Living in Home
1.	_____	_____	_____	From _____ To _____
2.	_____	_____	_____	From _____ To _____
3.	_____	_____	_____	From _____ To _____
4.	_____	_____	_____	From _____ To _____

Are there any other people who have a significant role in how this child is raised?
_____
_____

Educational Information:
List in chronological order all the schools your child has attended.

Name	System	Year(s)	Grade	Special Ed?
1. _____	_____	_____	_____	**Y/N**
2. _____	_____	_____	_____	**Y/N**
3. _____	_____	_____	_____	**Y/N**
4. _____	_____	_____	_____	**Y/N**

Name of Current School: _____
School Telephone Number: _____ Present Year: _____
Principal's Name: _____
Current Teacher: _____ Email: _____

Describe any recent interventions/actions by the school:
_____
_____

Has the child/adolescent been absent from school a lot? **Y / N**
If yes, please give reasons: _____
_____

What is the child/adolescent's attitude towards school?
_____
_____

What is the average amount of time that your child/adolescent spends on homework each night? _____

Describe any problems with homework: _____

Has your child received tutoring? In what area? For how long?
_____

Please describe any behavioural areas of concern (i.e. following rules/routines, completing chores, interacting with other children?)
_____

Does your child's teacher have concerns about him/her? (please list):
_____

What is your child's favorite subject/class? _____
What is your child's least preferred subject/class? _____

Has your child ever repeated a grade? **Y/N** If yes, what grades? _____

If your child has been in Special Education/Learning Support did they have:

- ☐ I.E.P
- ☐ Psychological Evaluation
- ☐ Speech Evaluation
- ☐ Behaviour Intervention Plan
- ☐ Occupational Therapy Evaluation
- ☐ Physical Therapy Evaluation
- ☐ Other(s) _____

If your child has been in Special Education/Learning Support please explain the services: _____
_____

Psychological History:

Is there a history in your immediate or in the mother's or father's extended family, of the following and if so who?

Yes	No		Who
___	___	Autism Spectrum Disorder	_____
___	___	Learning Problem/Disabilities	_____
___	___	ADHD–Attention Problems	_____
___	___	Depression/Anxiety	_____
___	___	Behaviour Problems in School	_____
___	___	Psychosis/Schizophrenia	_____
___	___	Substance Abuse/Dependence	_____
___	___	Other Mental Health Concerns	_____

Has the child you are seeking services for been evaluated in the past? **Y/N**
If yes, please list the following information on the previous evaluation(s):

	Who	Type	When	Copy Available?
1.	_____	_____	_____	**Y/N**
2.	_____	_____	_____	**Y/N**
3.	_____	_____	_____	**Y/N**
4.	_____	_____	_____	**Y/N**

If yes, what were the general findings and recommendations?
_____
_____

Has anyone in your immediate or extended family experienced with:

- ☐ Physical abuse, Explain _____
- ☐ Emotional abuse, Explain _____
- ☐ Verbal abuse, Explain _____
- ☐ Sexual abuse, Explain _____
- ☐ Sexual assault, Explain _____
- ☐ Alcoholism/drug use, Explain _____
- ☐ Other addictive behaviours, Explain _____

Discuss any significant recent life changes or past traumatic events that the child has experienced: _____

_____

Please provide us with any other information that you feel would be helpful to us in understanding your child: _____

_____

_____

Pre-natal and Delivery History:

Did the birth mother receive regular pre-natal care? **Y/N**
Where there any complications with the pregnancy? **Y/N**
If yes, please provide details: _____

_____

Was the birth at Full Term? **Y/N** If no, please provide details:

_____

Type of Delivery: Spontaneous/Induced Vaginal/C-Section

Complications in delivery? **Y/N** If yes, please provide details:

_____

_____

Birth Weight: ____ lbs ____ oz Apgar Scores: _____ _____

Concerns at Birth? **Y/N.** If yes, please provide details:

_____

_____

Is there any additional pre-natal or birth information that might be of assistance to us?

_____

_____

Developmental History:

Please indicate the approximate age at which your child did the following:

Rolled over consistently _____
Giggled/smiled at parents _____
Sat up unsupported _____
Stood _____
Crawled _____
Walked Unassisted _____
Responded to name with eye contact _____
Said 1st word intelligible to strangers _____
Said two-three word phrases _____
Used sentences regularly _____
Toilet trained during the day _____
Dry through the night (6+ months) _____
Dressed self _____

Please indicate if your child is experiencing any of the following:

- □ Problems with eating
- □ Isolated socially from peers
- □ Problems making friends
- □ Problems keeping friends
- □ Problems getting to sleep
- □ Problems controlling temper
- □ Problems sleeping through the night
- □ Trouble waking up
- □ Fatigue/tiredness during the day
- □ Nightmares
- □ Bed wetting
- □ Soiling
- □ Problems with authority
- □ Anxiety/Worry
- □ Unmotivated
- □ Stress from conflict with parents
- □ Legal situation (anyone in family)
- □ History of abuse
- □ Alcohol/Drug use/abuse
- □ School concentration difficulties
- □ Grades dropping/ consistently low
- □ Sadness or Depress

Please explain all items endorsed_____
_____
_____

Medical History

Name of child's primary physician: _____
Practice Name: _____
Address: _____
Phone Number: _____ Email: _____

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other special conditions your child has had:

_____
_____

Does your child have any allergies? _____

List any medications your child is currently taking or has taken for extended periods (give dates and dosage level, if possible):

_____
_____

Child's current height: _____ Ft _____ Inches Weight: _____ lbs

With which hand does your child write? _____

Glasses □ Yes □No
Please list date of last vision test and who performed (pediatrician, optometrist, school):
_____

Ever been concerned about your child's hearing? □ Yes□No
Please list date of last hearing test and who performed_____

Has your child ever had a seizure? □ Yes □No
If yes, date of the last seizure: _____

Other Professionals Involved:
Please provide information regarding any other professionals who may be involved in assisting with the current situation.

- □ Physician _____
- □ Psychiatrist _____
- □ Other _____

Please tell us about your Child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.

_____
_____
_____

List any special abilities, skills, strengths your child has: _____
_____
_____

Discipline Information:
Parents may use a wide range of discipline strategies with their children; some are listed below. Please rate how likely you are to use each of the strategies listed:

Intervention	**Very Unlikely**			**Very Likely**		**Effectiveness**
Let situation go	1	2	3	4	5	_____
Take away a privilege (ex. No TV)	1	2	3	4	5	_____
Assign an additional chore	1	2	3	4	5	_____
Take away something material	1	2	3	4	5	_____
Send to room	1	2	3	4	5	_____
Physical punishment	1	2	3	4	5	_____
Reason with child	1	2	3	4	5	_____
Ground child	1	2	3	4	5	_____
Yell at child	1	2	3	4	5	_____
Send to time out	1	2	3	4	5	_____
List anything else you may do:						
_____	1	2	3	4	5	_____
_____	1	2	3	4	5	_____

Go back and rate the THREE MOST effective strategies. That is, place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Please circle the LEAST effective.

General Information: Please list the five things you would like for your child to do more or and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviours such as do household chores, care for brothers and sisters, etc.

	Like Child to do More Often	**Like Child to do Less Often**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____