Outdoor Achievement Group, L.L.C.

Individual, Family, & Group Psychotherapy

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Parent Intake Questionnaire

Section I: Child's Personal Information & Emergency Contact Information

Child's Name (First, Middle Initial, Last): _____.

Parent(s)/Guardian(s): _____.

Date of Birth: _____/_____/_____ Current Age: _____ ☐Male ☐Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____ - _____ Mobile: (_____) _____ - _____

Email: _____

***Please include a color photograph of your child.**

Section II: General Intake Questions

1. Persons living in the same home as the child:

Name	Date of Birth or Age	Relationship to Child

2. Why are you seeking help for your child (please list problems)?

Section III: Developmental History

A. Prenatal History

1. How was the mother's health during pregnancy? ☐Good ☐Fair ☐Poor ☐Unknown
2. Did the mother experience unusual or high levels of stress during the pregnancy? ☐Yes ☐No

If yes, please explain

3. How old was the mother when the child was born? _____
4. Number of previous pregnancies? _____
5. Number of living children? _____
6. Did the mother experience a previous miscarriage or premature baby? ☐Yes ☐No

7. Do you recall using any of the following substances or medications during the pregnancy?

(circle appropriate answers)

Beer or Wine
Never
Once or Twice
3-19 Times
20-39 Times
40+ Times

Hard Liquor
Never
Once or Twice
3-19 Times
20-39 Times
40+ Times

Coffee and other Caffeinated Beverages
Never
Once or Twice
3-19 Times
20-39 Times
40+ Times

Cigarettes
Never
Once or Twice
3-19 Times
20-39 Times
40+ Times

8. Did you take any of the following substances?

_____ Valium (Librium, Xanax)
_____ Tranquilizers
_____ Ant seizure Medications (Dilantin, Phenobarbital)
_____ Antibiotics
_____ Sleeping Pills
_____ Narcotics
_____ Speed or Amphetamines
_____ Treatment for Diabetes
_____ Other; please specify: _____

9. Please indicate which occurred during your pregnancy with this child:

	Yes	No
Had Bleeding During the First Three Months		
Had Bleeding During the Second Three Months		
Had Bleeding During the Third Three Months		
Gained 30 or more Pounds		
Gained 15 or less Pounds		
Toxemia		
Rh Incompatibility		
Water Broke 24 Hours Before Delivery		
Eclampsia		
Vomited Often		
Got Hurt or Injured		
Experienced Shock or Unusual Stress		

10. Did you have any infections or illness during your pregnancy with this child? ☐Yes ☐No

If yes, please explain.

B. Perinatal History

11. How long was your pregnancy with this child? _____

12. How long was your labor? _____

13. Were you given any medications to ease the pain during labor? ☐Yes ☐No ☐Don't Know

If yes, please list medications.

14. Please mark all that apply to the child at the time of birth.

	Yes	No	?
Born with the Cord Around His or Her Neck			
Injured at Birth			
Indications of Fetal Distress			
Had Difficulty Breathing			
Was Jaundiced (yellow skin)			
Was Given Oxygen			
Was One of a Multiple Birth			
Had an Infection			
Was Given Medications			
Had Seizures			
Had Diarrhea			
Gagged Often			
Vomited Often			
Born with Heart or Other Congenital Defect			
Had Difficulty Sucking or Feeding			
Was Very "Jittery"			

Please list and explain other problems experienced during birth.

15. Please describe the delivery (check all that apply).

☐Normal ☐Cesarean ☐Induced ☐Breech ☐Forceps ☐Suction

16. What was the child's birth weight? _____

17. Did the child experience health complications after birth? ☐Yes ☐No

If yes, please explain.

18. Did the child have any birth Defects? ☐Yes ☐No

If yes, please explain.

19. APGAR Scores (if known): 1 Minute _____ 5 Minutes _____

20. How long did you stay in the hospital after the child's birth? _____

21. How long did the child stay in the hospital after birth? _____

C. Postnatal Period and Infancy

22. Please mark all that apply.

	Yes	No
Did the Infant Experience Feeding Problems		
Was the Infant Colicky		
Did the Infant Experience Sleep Pattern Difficulties		
Did You Experience Problems with the Infant's Alertness		
Meningitis		
Rotavirus		
Slow Weight Gain		
Anemia		
Lead or Other Poisoning		
Did the Infant Get Sick Following Immunization		

23. Please list and explain other problems experienced during infancy.

24. Did the child experience any health problems during infancy? ☐Yes ☐No

If yes, please explain.

25. Was the child an "easy" baby? Did the baby cry a lot? Did the baby follow a schedule well?

☐Very Easy ☐Easy ☐Average ☐Difficult ☐Very Difficult

26. Please mark the appropriate column for each behavioral dimension as an infant and toddler.

	Very	Somewhat	Neutral	Somewhat	Very	
Passive						**Demanding**
Carefree						**Anxious**
Indifferent						**Inquisitive**
Inactive						**Active**
Social						**Withdrawn**
Moody						**Even Temper**
Vocal						**Quiet**
Bashful						**Bold**

D. Developmental Milestones

27. Please use a checkmark to indicate the age at which the child first reached the following developmental milestones.

At what age did the child?	3-6 Months	7-12 Months	Over 12 Months	Don't Know
Sit Up				
Crawl				
Walk				
Speak Single Words (other than "mama or dada")				
String Two or More Words Together				
Toilet Trained (bladder control)				

28. Does the child currently have bladder control problems? ☐Yes ☐No

If yes, please indicate frequency and time of day.

If yes, has the child ever been continent? ☐Yes ☐No

29. At what age was the child toilet trained (bowel control)?

☐Under 1 Year ☐1-2 Years ☐2-3 Years ☐3-4 Years ☐Don't know

30. Does the child currently have bowel control problems? ☐Yes ☐No

If yes, please indicate frequency and time of day.

_____

_____

_____

_____

31. Approximately how long did toilet training take?

☐Less Than 1 Month ☐1-2 Months ☐2-3 Months ☐More Than 3 Months

32. In comparison to other children of his or her age, how well did the child perform the following tasks?

	Much Worse	Worse	About the Same	Better	Much Better	Not Applicable
Cutting with Scissors						
Pasting						
Dressing Self						
Coloring Within the Lines						
Working Puzzles						
Drawing Freehand						
Learning Colors						
Learning Shapes						
Learning Numbers						
Learning Alphabet						
Throwing a Ball						
Kicking a Ball						
Skipping						
Tying Shoelaces						
Running & Changing Directions						

Section IV: Medical History

1. Please use a checkmark to indicate the child's performance in the following areas.

	Very Good	Good	Fair	Poor	Very Poor
Hearing					
Vision					
Gross Motor Coordination					
Fine Motor Coordination					
Speech Articulation					

2. Has the child experienced any chronic health problems (e.g. asthma, allergies, diabetes)? ☐Yes ☐No

If yes, please describe and indicate age of onset.

3. Which of the following illnesses has the child had?

(circle all that apply)

Mumps	Chicken Pox
Measles	Whooping Cough
Scarlet Fever	Pneumonia
Encephalitis	Ear Infections
Seizures	Lead Poisoning
Allergies	Frequent Runny Nose
Frequent Colds	Frequent Sinus Infections

Has the child had other illnesses or diseases not listed above? If yes, please explain.

4. Did the child experience ear problems before the age of 1? ☐Yes ☐No

5. Approximately how many ear problems has your child experienced in his or her life?

   ☐0-2 ☐3-5 ☐6-10 ☐10+

6. Does the child tend to have 4 or more ear problems each year? ☐Yes ☐No

7. Has the child had an ear problem within the past 6 months? ☐Yes ☐No

8. Has the child ever had an ear problem that lasted 3 months or longer? ☐Yes ☐No

9. Has the child ever been seen by an ear doctor? ☐Yes ☐No

If yes, please provide the doctor's name, contact information, and date of last visit.

10. Has the child ever had tubes placed in her or her ears? ☐Yes ☐No

If yes, please indicate the child's age at the time of surgery.

11. Has the child's hearing ever been screened or checked? ☐Yes ☐No

If yes, please describe the findings and indicate the child's age at the time of screening.

12. Has the child's vision ever been screened or checked? ☐Yes ☐No

If yes, please describe the findings and indicate the child's age at the time of screening.

13. Has the child had any accidents resulting in the following?

	Yes	No
Broken Bones		
Head Injury		
Stomach Pumped		
Lost Teeth		
Sever Lacerations Requiring Stitches		
Severe Bruising		
Eye Injury		

14. Has the child suffered any serious accidents or injuries not indicated above? ☐Yes ☐No

If yes, please describe.

15. Approximately how many serious accidents or injuries has the child suffered?

☐None ☐1-3 ☐4-7 ☐8-12 ☐Over 12

16. Has the child ever had surgery for any of the following conditions?

	Yes	No
Tonsillitis		
Hernia		
Eye, Ear, Nose & Throat		
Urinary Tract Infection		
Burns		
Adenoids		
Appendicitis		
Digestive Disorder		
Leg or Arm		
Other:		

17. What was the duration of the child's hospitalization for the conditions described above?

☐1 Day ☐2-3 Days ☐4-6 Days ☐1-4 Weeks ☐1-2 Months ☐Over 2 Months

18. Do you suspect the child is currently or has ever used alcohol or drugs? ☐Yes ☐No

If yes, please describe suspicions.

19. Does the child have any problems sleeping? ☐Yes ☐No

If yes, please describe.

20. Is the child a restless sleeper; are his or her bed covers often in disarray in the morning? ☐Yes ☐No

21. Does the child snore? ☐Yes ☐No ☐Don't Know

22. Sleep Efficiency:

What time does the child get in bed for the night?	
What time does the child fall asleep?	
How many times does the child wake during the night?	
How long does it take for the child to fall back asleep after waking?	
What time does the child wake up in the morning?	
What time does the child get out of bed in the morning?	

23. Does the child have any appetite control problems? ☐No ☐Overeats ☐Under eats

24. Is the child currently receiving treatment for any non-mental health related conditions? ☐Yes ☐No

If yes, please describe & provide their physician's contact information.

25. Is the child currently taking any medications? ☐Yes ☐No

If yes, please list current medications and dosages.

Section V: Treatment History

1. Has the child ever been prescribed any of the following medications?

	Yes	No	If Yes, Age & Duration of Use
Stimulants/ADHD			
dexmethylphenidate (Focalin)			
dextroamphetamine (Adderall)			
lisdexamfetamine (Vyvanse)			
methylphenidate (Concerta; Metadate; Ritalin)			
Selective Norepinephrine Reuptake Inhibitor			
Atomoxetine (Strattera)			
Antipsychotic			
aripiprazole (Abilify)			
lurasidone (Latuda)			
olanzapine (Zyprexa)			
quetiapine (Seroquel)			
risperidone (Risperdal)			
Alpha-2 Receptor Agonist			
clonidine (Catapres)			
guanfacine (Intuniv)			
Anxiolytics/Hypnotics			
alprazolam (Xanax)			
buspirone (Buspar)			
clonazepam (Klonopin)			
zolpidem (Ambien)			
Selective Serotonin Reuptake Inhibitors (SSRIs)			
citalopram (Celexa)			
escitalopram (Laxapro)			
fluoxetine (Prozac)			
fluvoxamine (Luvox)			
paroxetine (Paxil)			
sertraline (Zoloft)			
Antidepressants - Other			
bupropion (Wellbutrin)			
mirtazapine (Remeron)			
Anticonvulsants			
carbamazepine (Tegretol)			
lamotrigine (Lamictal)			
oxcarbazepine (Trileptal)			
Antihistamines			
Other Prescription Drug(s):			

2. Has the child ever participated in any of the following forms of psychological treatment?

	Yes	No	If Yes, Age & Duration of Treatment
Individual Psychotherapy			
Group Psychotherapy			
Family Therapy with Child			
Inpatient Evaluation			
Residential Treatment			

Section VI: School History

Current School: _____ Grade: _____

1. Please summarize the child's school progress. Include details such as grades, any formal testing that was completed, how the child interacted with peers and teachers, and any pertinent behavioral issues.

Kindergarten

Grades 1-3

Grades 4-6

Grades 7-9

Grades 10-12

2. Have any in structural modifications been attempted (e.g., IEP or 504 Plan)? ☐Yes ☐No

If yes, please describe the program and indicate duration.

3. Has the child ever been:

	Yes	No	If Yes, How Many Times?
Suspended from School			
Expelled from School			
Received Lunch Detention or After School Detention			
Retained in Grade			

4. Please use a checkmark to indicate the child's performed in the following subjects?

	Below Average	Average	Above Average
Reading			
Spelling			
Math			
Writing/Penmanship			
Social Studies			
Science			
English/Language Arts			

Section VII: Current Behavioral Concerns

1. What strategies have been tried to address specific behavioral problems?

☐ Verbal Reprimand
☐ Time Out (isolation)
☐ Removal of Privileges
☐ Rewards
☐ Physical Punishment
☐ Acquiescence of Child (giving in)
☐ Avoidance of Child

2. On average, what percentage of time does your child comply with initial commands?

☐0-20% ☐20-40% ☐40-60% ☐60-80% ☐80-100%

3. On average, what percentage of time does your child eventually comply with commands?

☐0-20% ☐20-40% ☐40-60% ☐60-80% ☐80-100%

4. To what extent are you and your spouse consistent with respect to disciplinary strategies?

☐Most of the Time ☐Some of the Time ☐None of the Time

Questions 5-8 ADHD Rating Scale – 5 for Children and Adolescents

5. Which of the following symptoms of **INNATTENTION** have persisted for at least six months to a degree that inconsistent with your child's developmental level and that negatively impacts directly on social and academic activities? Please read each statement carefully. Indicate **How often does your child displays this behavior?**

0	1	2	3
Never or Rarely	Sometimes	Often	Very Often

_____ Fails to give close attention to details or makes careless mistakes in schoolwork or during other activities.

_____ Has difficulty sustaining attention in tasks or play activities.

_____ Does not seem to listen when spoken to directly.

_____ Does not follow through on instructions and fails to finish schoolwork or chores.

_____ Has difficulty organizing tasks and activities.

_____ Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework).

_____ Loses things necessary for tasks or activities (e.g., school materials, pencils, books, eyeglasses).

_____ Easily distracted.

_____ Forgetful in daily activities (e.g., doing chores).

6. Please read each statement carefully. Indicate **How much do the nine behaviors in the previous questions cause problems for your child?**

0	1	2	3
Never or Rarely	Sometimes	Often	Very Often

_____ Getting along with family members.

_____ Getting along with other children.

_____ Completing or returning homework.

_____ Performing academically in school.

_____ Controlling behavior in school.

_____ Feeling good about himself/herself

7. Which of the following symptoms of **HYPERACTIVITY-IMPULSIVITY** have persisted for at least six months to a degree that inconsistent with your child's developmental level and that negatively impacts directly on social and academic activities? Please read each statement carefully. Indicate **How often does your child displays this behavior?**

0	1	2	3
Never or Rarely	Sometimes	Often	Very Often

_____ Fidgets or taps hands or feet or squirms in seat.

_____ Leaves seat in situations when remaining seated is expected.

_____ Runs about or climbs in situations where it is inappropriate.

_____ Unable to play or engaging in leisure activities quietly.

_____ "On the go," acts as if "driven by a motor".

_____ Talks excessively.

_____ Blurts out answers before a question has been completed.

_____ Has difficulty awaiting his or her turn (e.g., while waiting in line).

_____ Interrupts or intrudes on others.

8. Please read each statement carefully. Indicate **How much do the nine behaviors in the previous questions cause problems for your child?**

0	1	2	3
Never or Rarely	Sometimes	Often	Very Often

_____ Getting along with family members.

_____ Getting along with other children.

_____ Completing or returning homework.

_____ Performing academically in school.

_____ Controlling behavior in school.

_____ Feeling good about himself/herself

9. Please read each statement carefully and select those that apply to your child.

☐ Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.

☐ Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home or school; with friends or relatives; in other activities).

☐ Symptoms interfere with, or reduce the quality of, social or academic functioning.

10. Which of the following are considered to be significant problems at the present time?

	Yes	No	If Yes, Age of Onset
Often Loses Temper			
Often Argues with Adults			
Often Defiant or Refuses to Comply with Adults' Requests			
Often Deliberately Annoys People			
Often Blames Other for His or Her Mistakes			
Is Easily Annoyed by Others			
Often Angry or Resentful			
Often Spiteful or Vindictive			

11. Which of the following are considered to be significant problems at the present time?

	Yes	No	If Yes, Age of Onset
Often Bullies, Threatens, or Intimidates Others			
Often Initiates Physical Fights			
Has Used a Weapon Capable of Causing Serious Harm to Others			
Has Been Physically Cruel to People			
Has Been Physically Cruel to Animals			
Has Stolen While Confronting the Victim (face to face with the victim)			
Has Forced/Coerced Someone into Sexual Activity			
Has Deliberately Set a Fire with the Intention of Causing Serious Damage			
Has Deliberately Destroyed Others' Property			
Has Broken into Someone Else's House, Car, or Building			
Often Lies to Obtain Goods, Favors, or to Avoid Obligations			
Has Stolen Items of Value Without Confronting Victim			
Often Stays Out at Night Past Curfew			
Has Run Away from Home Overnight			
Often Truant from School			

12. Which of the following are considered to be significant problems at the present time?

☐ Excessive distress when separation from home or attachment figures occurs or is anticipated?

☐ Excessive worry about losing, or possible harm befalling, major attachment figures?

☐ Excessive worry that an event such as getting lost or being kidnapped will result in separation from a major attachment figure?

Section VIII: Family, Social History, & Religious History

1. Where was the child born (City, State)? _____
2. Who was the child raised by? _____
3. Are the child's parents divorced? ☐Yes ☐No

If yes, please answer questions 4-8

4. How old was the child at the time of the divorce? _____
5. Who has legal custody of the child? _____
6. Has either parent remarried? ☐Yes ☐No

If yes, please explain.

_____

_____

_____

_____

7. Who does the child currently live with? _____
8. What are the visitation agreements?

_____

_____

_____

_____

9. Does the child have siblings living at home? ☐Yes ☐No

If yes, list the name and age of siblings living at home, and describe relationship.

_____

_____

_____

_____

10. Does the child have siblings not living at home? ☐Yes ☐No

If yes, list the name and age of siblings not living at home, and describe relationship.

_____

_____

_____

_____

11. Describe the child's relationship with parent(s) or guardian(s):

12. Describe the parent's relationship with spouse or significant other.

13. Does the child have close friends? ☐Yes ☐No

If yes, list the first name and age of close friends, and describe relationship.

14. Describe the child's relationship with casual peers/schoolmates.

15. Describe the child's relationship with teachers and other adults.

16. Was the child raised in a religious household? ☐Yes ☐No

If yes, please describe religious upbringing.

17. Is the child or family currently associated with any religious organizations? ☐Yes ☐No

If yes, please describe religious affiliations.

18. Is the child sexually active? ☐Yes ☐No ☐Don't Know

If yes, has the child ever been tested for Sexually Transmitted Disease (STD)? ☐Yes ☐No ☐Don't Know

19. Please indicate whether the child has experienced the following events.

	Yes	No	If Yes, How Old Was the Child
Family Moved to a New Home			
Child Changed Schools			
Child Separated from Family for 2-Weeks or More			
Brother or Sister Leaving Home			
Divorce of Parents			
Increase in Arguments Between Parents			
Decrease in Arguments Between Parents			
Marital Separation of Parents			
Being Raised by a Single Parent			
Multiple Caregivers			
Parent Has a Live-In Boyfriend or Girlfriend			
Marriage of Parent to Stepparent			
Addition of Step Brothers or Sisters to the Household			
Birth of a Sibling or Mother Becomes Pregnant			
Non-Family Member Living with the Family			
Addition of a Third Adult to the Family			
Mother Begins Work			
Change in Father's Occupation Requiring Increase Absence from Home			
Improvement in Parent's Financial Status			
Worsening of Parent's Financial Status			
Loss of Job by Parent			
Child is a Victim of Violence			
Family Member a Victim of Violence			
Child Acquired a Visible Deformity			
Brother or Sister Experiences Serious Trouble			
Parent Arrested or in Serious Trouble with the Law			
Serious Illness or Accident Requiring Hospitalization of Child			
Serious Illness or Accident Requiring Hospitalization of Brother or Sister			
Serious Illness or Accident Requiring Hospitalization of Parent			
Death of a Brother or Sister			
Death of a Parent			
Death of a Grandparent			
Death of a Friend			
Parent Began Counseling			
Parent's Mood or Feelings About Life Became Worse or Much Worse			
Parent's Mood or Feelings About Life Became Better or Much Better			
Discovery by Child of Being Adopted			
Suspicion of Sexual Abuse			
Suspicion of Physical Abuse			
	Yes	**No**	**If Yes, How Old Was the Child**

20. At any point since the child was born, have they experienced any of the following adverse events?

	Yes	No	For Office Use Only
Child's Parents or Guardians were Separated or Divorced			
Child Lived with a Household Member Who Served Time in Jail or Prison			
Child Lived with a Household Member who was Depressed, Mentally Ill or Attempted Suicide			
Child Saw or Heard Household Members Hurt or Threaten to Hurt Each Other			
A Household Member Swore at, Insulted, Humiliated, or Put Down Your Child in a Way That Scared Your Child or a Household Member Acted in a Way That Made Your Child Afraid That They Might be Physically Hurt			
Someone Touched Your Child's Private Parts or Asked Your Child to Touch Their Private Parts in a Sexual Way			
More Than Once, Your Child Went Without Food, Clothing, a Place to Live, or Had No One to Protect Them			
Someone Pushed, Grabbed, Slapped or Threw Something at Your Child or Your Child Was Hit So Hard That Your Child Was Injured or Had Marks			
Your Child Lived with Someone Who Had a Problem with Drinking or Using Drugs			
Your Child Often Felt Unsupported, Unloved and/or Unprotected			
Adverse Childhood Experiences (ACEs) Questionnaire Score			

21. Please use a checkmark to indicate behaviors which apply to the **child's biological father and his family**.

	Father	Father's Mother	Father's Father	Father's Brother	Father's Sister
Problems with Aggressiveness, Defiance, and Oppositional Behaviors					
Problems with Attention, Activity, and Impulse Control as a Child					
Learning Disabilities					
Did Not Graduate from High School					
Mental Retardation					
Psychosis or Schizophrenia					
Bipolar Disorder or Manic Depression					
Depression					
Anxiety Disorder That Impaired Adjustment					
Tics or Tourette's					
Alcohol or Substance Abuse					
Problems with the Law					
Physical Abuse as a Child					
Sexual Abuse as a Child					

22. Please use a checkmark to indicate behaviors which apply to the **child's biological mother and her family**.

	Mother	Mother's Mother	Mother's Father	Mother's Brother	Mother's Sister
Problems with Aggressiveness, Defiance, and Oppositional Behaviors					
Problems with Attention, Activity, and Impulse Control as a Child					
Learning Disabilities					
Did Not Graduate from High School					
Mental Retardation					
Psychosis or Schizophrenia					
Bipolar Disorder or Manic Depression					
Depression					
Anxiety Disorder That Impaired Adjustment					
Tics or Tourette's					
Alcohol or Substance Abuse					
Problems with the Law					
Physical Abuse as a Child					
Sexual Abuse as a Child					

23. Please use a checkmark to indicate behaviors which apply to the **child's biological siblings**.

	Brother	Brother	Sister	Sister
Problems with Aggressiveness, Defiance, and Oppositional Behaviors				
Problems with Attention, Activity, and Impulse Control as a Child				
Learning Disabilities				
Did Not Graduate from High School				
Mental Retardation				
Psychosis or Schizophrenia				
Bipolar Disorder or Manic Depression				
Depression				
Anxiety Disorder That Impaired Adjustment				
Tics or Tourette's				
Alcohol or Substance Abuse				
Problems with the Law				
Physical Abuse as a Child				
Sexual Abuse as a Child				

Section IX: Narrative

1. In the space provided below please write a few paragraphs outlining your child's current behavioral, emotional, and or psychological behavior patterns. When possible, please provide specific examples. If necessary, you may attach additional sheets or use the back of this page.

2. In the space provided below please write a few paragraphs describing the marital relationship or parent's relationship with significant other(s).

Section X: Child's Self-Assessment (for children and adolescents aged 8-12)

Hello, my name is _____. I am _____ years old.

These are some of my favorite activities:

For the most part I would describe myself as a _____ person.

These are some of the things I would like to change about my life:

This is how I would describe my relationship with close friends:

This is how kids at school would describe me:

This is how I would describe myself: