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**CHILD/MINOR – Confidential Intake Questionnaire**

*To be completed by a parent. PHQ and GAD to be completed by the child/minor. You can email the completed forms with the understanding that email is not a confidential form of communication, or provide me with a hardcopy.*

*These questions are intended to help me understand what you hope to gain from counseling, and some general information about your child’s overall wellbeing and history. You are not obligated to answer every question; please skip any items that makes you uncomfortable.*

**About your child:**

Name:       Today’s date:       Birth date:

Mailing/primary address:

Age:       Sex at birth:       Preferred gender:

Phone #:

School:       Grade:

Emergency Contact name:      Emergency contact #:

**About you:**

Your phone #:       Preferred email:       Preferred means of contact:

Other parents name and phone #:

Is there split custody for medical decisions? Yes ; No

Is your child adapted? Yes ; No

**About this appointment:**

How did you learn about me/my practice?

If applicable, is it okay for me to thank whomever referred you to me? Yes ; No

Why have you scheduled this appointment?

In what way are you hoping your child will benefit from attending therapy?

**Mental health treatment:**

If your child previously met with a therapist, please indicate who, when, and for what reason:      

Has your child been hospitalized for psychiatric reasons? Yes ; No

Is your child currently prescribed psychiatric medication? Yes ; No

If your child has been diagnosed with a health condition (mental or physical), please identify what it is and when they were first diagnosed:

If your child has a close, biological family member with mental illness, who is it, and what is the diagnosis?

**General questions:**

How would you describe the relationship between this child’s parents?

Who resides in this child’s home (name, age, relationship to child)?

How would you describe the social, emotional, physical and cognitive development of your child?

What activities does your child participate in (e.g., sports, clubs, hobbies)?

Please identify any traumatic or significant events in your child’s life (e.g., divorce, death of a parent, illness or injury):

Please take a moment to let me know more about your child as a whole person, such as their interests, accomplishments, skills, future ambitions, or activities:

**Please identify those areas which concern you about your child (otherwise leave blank):**

|  |  |
| --- | --- |
| Mood concerns:  Depression (sadness):  Anxiety (worry):  Panic attacks or fearfulness:  Quickly changing moods:  Easily irritated/short-fused:  Life feels meaningless:  No future goals or ambitions:  Few interests or hobbies:  History of suicide attempt(s):  Currently suicidal ideation: | Physical concerns:  General health concerns:  Low energy/tired:  Chronic health condition:  Chronic pain:  Difficulty sleeping:  Problems with weight:  Poor eating habits:  Lack of exercise:  Self-harm (cut/burn self): |
| Cognitive/executive functioning concerns:  History of concussions:  History of brain trauma:  Procrastination:  Poor concentration/attention:  Disorganized:  Trouble thinking clearly:  Bizarre/frightening thoughts: | Social/relationship concerns:  Loneliness/isolated:  Few friends:  Poor social skills:  Defiance or anger:  Death of family member:  Conflict with family member:  Dependent – Insufficient autonomy:  Lacking assertiveness skills:  Anger management problems: |
| Educational concerns  School dissatisfaction:  School refusal:  Homework refusal:  Learning challenges:  Behavioral concerns  Immaturity  Unable to hear “no”  Tantrums/acting out  Unusual/bizarre behavior  Disrespectful to authority | Other concerns:  History of drug/alcohol abuse:  Current drug/alcohol abuse:  Addiction to pornography:  Addiction to gaming:  Childhood emotional abuse:  Childhood physical/sexual abuse:  Legal problems:  Other: |

**The below questionnaires are to be completed by children ages 11-18**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Health Questionnaire PHQ-A  How often have you been bothered by each of the following symptoms during the past **7 days**? | | | | |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Trouble falling/staying asleep, sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself, or that you are a failure, or have let yourself or your family down |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching TV |  |  |  |  |
| Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual |  |  |  |  |
| Thoughts that you would be better off dead or of hurting yourself in some way |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anxiety GAD-7  Over the last **two weeks** how often have you been bothered by any of the following problems? | | | | |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Feeling nervous, anxious or on edge |  |  |  |  |
| Not being able to stop or control worrying |  |  |  |  |
| Worrying too much about different things |  |  |  |  |
| Trouble relaxing |  |  |  |  |
| Being so restless that is hard to sit still |  |  |  |  |
| Becoming easily annoyed or irritable |  |  |  |  |
| Feeling afraid as if something awful might happen |  |  |  |  |

If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all; Somewhat difficult; Very difficult; Extremely difficult

*Thank you for taking the time to answer these questions. I look forward to discussing your responses when we meet.*