Stockbridge-Munsee Behavioral Health Child Intake Questionnaire

Name: _____ **DOB:** _____ **Today's Date:** _____
Presenting issue (why are you bringing your child here) _____
_____
_____

Tribal Member? Yes / No What Tribe? _____

How long has this been an issue: _____
Were you referred? Yes / No If yes, by whom? _____

Family history: (parents, siblings, childhood, etc.): _____
_____
_____

Housing arrangement: _____

Financial situation: _____
AODA/Mental Health family history: _____
_____

Abuse/trauma history: (past and present) _____
_____
_____

Grief/loss history: _____
_____

Developmental history: (normal pregnancy, milestones, AODA use while pregnant, etc.):
_____

Medical history: _____

Please provide information about any prescribed and/or over-the-counter medication your child takes regularly.

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

Current diet: (healthy, junk food, diabetic, etc.): _____

School information:

What school does your child attend? _____

What grade is your child in: _____

Does your child have an IEP? Yes / No
Is your child experiencing any issues at school? Yes / No If yes, please explain:

_____
_____
_____

Social relationships: (describe friends): _____
_____

Cultural/spiritual practices: _____

Hobbies/Favorite activities: _____

What are strengths for your child? _____

What are strengths within your family? _____
_____

What are any challenges for your child? _____

What are any challenges for your family? _____
_____

Who is in your child's support network? (family, friends, teachers, etc.):
_____
_____

Anything else we should know about your child's situation? Yes / No
Please explain: _____
_____
_____
_____

Alcohol/Drug Use History	What Type/Method of use?	Age of first use	How much used each time?	How often is client using? (Daily, weekends, monthly)	Date of last use?
Alcohol					
Cannabis					
Cocaine					
Stimulants					
Opiates					
Suboxone Subutex					
Benzos					
Hallucinogens					
Depressants					
Inhalants					
Steroids					
Synthetic Marijuana					
Over the Counter					