USF Diabetes Center
Morsani Center, 5th Floor
13330 Laurel Dr.
Tampa, FL 33612

Psychology Intake Questionnaire

Please complete the following questionnaire and bring to your child/teen's first appointment with Dr. Smith. In general parents should complete this form rather than children or teens. Completing this questionnaire will help Dr. Smith learn about your child's history and current difficulties.

Section I. Child/Teen Identifying Information

Full name: _____ Gender: _____ Male _____ Female

Preferred name/nickname: _____ Date of Birth: _____

Address _____

City: _____ County: _____ State: ____ Zip: _____

Primary phone: _____ Can we leave a message? ____ Yes ____ No

Alternate phone: _____ Can we leave a message? ____ Yes ____ No

Section II. Parent Information

Mother's name: _____ Age: _____

Mother's occupation: _____ Highest grade completed: _____

Father's name: _____ Age: _____

Father's occupation: _____ Highest grade completed: _____

Who has legal custody of child: _____

Are the child's parents married? ____ Yes ____ No

Separated? ____ Yes ____ No If yes, when? _____

Divorced? ____ Yes ____ No If yes, when? _____

Section III. Child/Teen Background Information

Please list name, age, and relationship of all people living in the child's home:

	First Name	Age	Relationship to child
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Educational History:

Highest grade completed by child or current grade: _____

Current school (if applicable): _____

Typical grades: _____ Has your child ever repeated a grade?_____

Does your child have an IEP or a 504 Plan? If yes, please explain reason.

_____

_____

Has your child been suspended or expelled from school? If yes, please explain.

_____

_____

Medical History:

When was your child diagnosed with diabetes? _____

Please list any other medical conditions your child has. _____

_____

Does your child or anyone in your family have a history of mental health or learning problems such as depression, anxiety (nerves), ADHD, bipolar disorder, or another mental health concern? Please list family members and the condition they had/have.

_____

_____

_____

What medications does your child take? _____

Who is your child's primary care doctor? Doctor's Name: _____

Name of doctor's practice or office: _____

What doctor takes care of your child's diabetes? Doctor's Name: _____

Name of doctor's practice or office: _____

Section IV. Current Concerns

Who referred your child for psychological services? _____

Has your child seen by a psychologist, counselor, social worker, or psychiatrist? If yes, when and for what concern(s)._____

_____

Briefly describe the problem that brings your child in for psychological services.

_____

_____

_____

_____

_____