OCD Intake Questionnaire Child/Adolescent

Client Information	
Client Name:	Date of Birth (yyyy-mon-dd):
Parent/Guardian Name:	Phone Number:
Family Physician:	

Current Concern

What is the concern that led you to seek therapy for your child?

What should I know about your child and family to better understand the situation?

What are your expectations of therapy and how will you know when your child no longer requires therapy?

Identify your child's positive and challenging behaviours.

Medical History

Please list any health issues your child has:

Please list any medications your child is taking:

Mental Health History

If your child has had previous experience with mental health services, please describe the circumstances, any diagnosis given and any treatments provided.

Please list your child's obsessions (involuntary images, thoughts or impulses that occur repeatedly in their mind)
Please list your child's compulsions (behviours or rituals they feel compelled to do to relieve the anxiety caused by obsessions)