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Mon.,Tue.,Thurs., Fri. 9:00 am – 2:00 pm
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Intake questionnaire for parents/ care takers

From page 6 onwards, there is a list of questions for clients aged 12 +. In this case do fill in and send the first five pages of the parents' list of questions too.

Information about the child:

First name(s) gender
Surname
Date of birth (d-m-yyyy)
Address
Post code + City
Telephone number

Information about the parents/ care takers:

Mother / care taker :

First name
Surname
Date of Birth (d-m-yyyy)
Address + post code
Telephone number
Mobile number
email address of the parent

Father / care taker:

First name
Surname
Date of Birth (d-m-yyyy)
Address + post code
Telephone number
Mobile number

Name of family doctor:

address
telephone number

Child's Citizen registration Number (Burger Service Nummer)

Does he/ she get treated (or ever was) by another professional or / (medical) specialist?
(What for, by whom, when)

Does or did your child use medication?
If yes, since when and which ones?

Have you noticed singularities in the development of your child?
(for example delays or abnormalities)

Information regarding the family and family situation

What is your relation with the child who you are registering?
(for example own child, child adopted by your family, foster child, etc...)

Describe your family structure and mention peculiarities
(such as divorce, recombined family, etc...)

Does the child have brothers / sisters? (name and age)
(do they live at the same address?)

In case of divorce between the parents:

Since when?

Do both parents have parental authority/ joint authority?

Give a short description of an visit rights plan

What language(s) does your child speak at home?
Which is the main language your child uses to communicate?

Information about school/ education/ care facilities

What sort of school or institution does your child attend during the day?

school name+ address /tel

class / group

teacher/- s (name-s)

did he/ she retake/accelerate a year?

Does your child experience severe problems or long term problems at school or their institution?

If yes, which ones? Learning difficulties, behavioral issues, relationship problems, etc..

What are the reasons for registering your child? What would you like being assessed?

In case of therapy, how long has she/he had this issue/ trouble for?

What do you expect from this appointment/assessment/therapy?

Does your child experience the reason for their registration as an issue too?

In case of an assessment: is he/ she motivated?
(briefly explain)

Is your child motivated for therapy?
(briefly explain)

What does your child expect from the appointment/ assessment/ therapy?

Did your child ever have to deal with very tough/ traumatic situations?
(for example accidents, hospital stays, illness(es), mistreatment, abuse, grief through someone losing their life)

Information about the behaviour and experience of the child

How does the child react to new unknown situations, how do they cope with changes?

What is the general mood of your child?

Are there non logical anxieties? If so, which ones? How do they appear?

How does your child cope with loss/ frustration?

How ingenious and creative is your child?
(briefly explain)

How full of life and energetic is your child?

Is your child self-reliant or dependent?

Does your child have difficulties paying attention or concentrating while busy with a task?

Is your child hyperactive, impatient or impulsive? (first doing then thinking?)
(fidgety, restless, unable to sit still?)
(give a brief description)

What are the most important activities of your child at home?
(hobbies, abilities)

What does your child (absolutely) dislike?

How does your child interact with others?

in contact with adults

in contact with peers

in contact with "strangers"
(describe)

Does your child experience (tone) specific problems with social contact?

Sensing acceptable/unacceptable behaviour

Being bossy

Being bullied
(give a brief description)

Did your child experience major difficulties learning rules and manners? (e.g. accepted/unaccepted behaviour?)

In forms of stealing

In forms of lying

Rebellious/ hardheaded

The information obtained in this questionnaire is used for planning therapy or counselling.

To ask third party advice or sharing this questionnaire I would always have to ask you for your authorization doing so.

In case of shared or equal authority between divorced parents, both parents have to agree on starting therapy.

Date and place:

Signature:

Questionnaire for adolescent clients above 12 years

Leave your own email-/ address and mobile telephone number here.

Do you think that you need help?

If so, what issue/problems would you like to seek help for?

What do you most enjoy doing? (i.e.hobbies, sports)

What do you (absolutely) dislike?

What do you dislike doing?

What do you regularly suffer from?

What are your strengths? What are you good at?

What are you not (very) good at, what are your weak points?

What would you like to change in yourself?

What would you like to change in your environment?

Please check the required box in the following table describing which issues are not true, sometimes/or a bit true or definitely true for you.

	Not true	Sometimes true, or a bit true	Not true
1. I feel good about myself			
2. I am regularly scared of something			
3. I am an insecure person			
4. I don't worry about anything			
5. I find it difficult adapting to change			
6. A lot of times I have a restless mind.			
7. I can relax well			
8. I always get what I want			
9. I am feeling depressed			
10. I easily make contact with people of my age group			
11. I hate to make mistakes			
12. I am athletic			
13. I can't bear my loss			
14. I am popular amongst peers			
15. I avoid difficulties			
16. I love adventure			
17. I sometimes feel ashamed			
18. I hate arguments			
19. I feel misunderstood			
20. I trust future			

Write down if you want to share anything else:

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To ask third party advice or sharing this questionnaire I would always have to ask you for your authorization of doing so.

Date and place:

Signature: