PATHS
Psychological and Therapeutic Healing Services, PLLC

Child and Adolescent Intake Form

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before the child/adolescent is evaluated. Please read the questions carefully and answer them as fully as possible. Use extra paper if necessary. Thank you.

Identifying Information

Legal Name: _____ Preferred name: _____

Date of Birth: _____ Age: _____ Sex: ___ Male. ___ Female

Race: ___ Caucasian ____ African American ____ Hispanic ____ Native American

___ Asian ___ Other: _____

Person completing this form: _____

Relationship to child/adolescent: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Child's Doctor: _____ Phone: _____

Referral (Reason and Source)

Referred by: _____

Reason for Seeking Services: _____

_____

_____

_____

_____

When did you first notice problems? _____

_____

_____

Occurs how often: _____

Has anyone else in the family had similar problems? If so, who? _____

_____

Previous attempts to deal with problem and results: _____

Prior problems/legal: _____

Recent life stressors? _____ Yes ____ No (if yes, please specify): _____

_____

Past Psychiatric Treatment History

Outpatient Counseling/Therapy (If yes, when and where): _____

_____

Inpatient Treatment (If yes, when, where, and for how long): _____

_____

Current psychiatric Medication: _____

Family/Social History:

Biological Mother: _____ Age: _____ Education: _____

Occupation: _____ How Long: _____

Biological Father: _____ Age: _____ Education: _____

Occupation: _____ How Long: _____

Child/Adolescent is living with:

_____ Both parents _____ Mother _____ Father _____ Mother and Step-father

_____ Father and Step-mother _____ Mother and Mother _____ Father and Father

_____ Legal Guardian _____ Other (Please specify): _____

Who lives in the home with the child/adolescent?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If the child/adolescent does not live with both parents, what are the visitation arrangements?

_____

Are parents able to co-parent? If no, explain: _____

_____

Has the child/adol lived with any other person besides the parent? _____

Has the child/adol ever been physically, sexually, or emotionally abused or neglected? If yes, please explain and has this been reported to CPS?:_____

_____

Has the child ever witnesses violence in the home or had a severely traumatic experience?

Please explain: _____

Has CPS been involved with the family? If yes, please explain: _____

_____

Family Stressors: _____ death _____ separation/divorce _____ remarriage _____ adoption

_____ moves _____ military duty

Has the child/adol ever attempted suicide? _____

Has the child/adol ever engaged in self-cutting/self-harm? _____

Has the child/adol ever had thoughts of harm towards others? _____

When you child/adol is upset how does he/she respond? (check all that apply)

___ talk to someone/journal ___ become depressed ___ become anxious ___ eat

___ withdraw/isolate ___ become angry/yell ___ use alcohol/drugs ___ hit/throw things

___ engage in physical activity ___ sleep ___ other: _____

Major methods of discipline: _____ take away privileges _____ send to his/her room

_____ talk to him/her _____ spank with hand _____ spank with object _____ physical activity

_____ other: _____

Who handles discipline? _____ Do parents agree? ___ Yes ___ No

Child's reaction to discipline: _____

Family physical/mental health history (please identify):
Biological Mother; Biological Father; Sibling; Mother's Mother (MGM); Mother's Father (MGF); Father's Mother (PGM); Father's Father (PGF); Aunt; Uncle; Other

Depression	
Anxiety	
Intellectual Disability	
Learning Disorder	
Developmental Disability (Autism)	
Conduct Disorder	
Schizophrenia	
Alcoholism	
Bipolar Disorder	
Suicide (or attempts)	
Other mental illness	
Other:	

Developmental History:

Was this a planned pregnancy? ____ Yes ____ No

Did the mother use any drugs, alcohol, cigarettes or medication while pregnant? _____

_____

Complications during pregnancy or at birth for mother or child? _____

_____

Child/Adol's birth weight _____ lbs _____ ozs

Child's temperament as an infant: _____ happy _____ fussy _____ difficult _____ colic
_____ illness _____ poor sleeper _____ didn't like to be held

What age did your child: _____ crawl _____ walk _____ talk

_____ toilet trained day _____ toilet trained night

Did you have any concerns about your child/adol's development? Please explain. _____

_____

Does your child/adol have sensory/motor issues? Please explain _____

_____

Does your child/adol have speech issues? Please explain _____

_____

Does your child use/need: _____ glasses _____ contacts _____ hearing aids _____ walker

Medical problems/allergies: _____

_____

History of head trauma: _____

_____

Menstrual cycle (if applicable): ____ regular _____ irregular _____ birth control: _____

Physical complaints: _____ headaches _____ stomaches _____ other: _____

Sleep difficulties: _____ falling/staying asleep _____ nightmares _____ restless _____ by self

____ wets bed ____ hard to wake _____ Typical bed time _____ Time to get to sleep

Appetite: ____ average ___ picky _____ poor _____ recent decrease _____ recent increase

Eating habits: _____

School History

Any separation difficulties when child attended daycare/preschool/school? _____

_____

Child ever repeated a grade? If yes, which one? _____

Typical grades: _____

Recent change in grades? _____

Suspended/expelled? _____

Current school and grade: _____

How many schools has your child attended? _____

Has your child ever been tested for learning disabilities, IQ, etc? _____

Tutoring: _____

Does your child have a current IEP? _____ Yes _____ No 504 Plan ____ Yes ___ No

Gifted/AP classes? _____

Does your child get along with other children? _____

Social Activities: _____

Any behavior problems at school? _____

Social History

Is your child sexually active? ____ Yes _____ No _____ Unknown

Does your child use substances? _____ Yes ____ No Age of first use: _____

Child/Adol strengths: _____

_____

Child/Adol limitations: _____

_____

Nature Exposure

How often does your child go outside? _____

Does your child/adol enjoy spending time in nature? _____

Any favorite outdoor activities? _____

Has your child/adol been tested for vitamin D levels? _____

Free Time

How does your child/adol prefer to spend free time? _____

Hours spent on a screen (e.g., television, video games, tablet, cell phone) per day: _____