Pathways Counseling
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Original Date:
Dates Revised:

HEALTH HISTORY/INTAKE INFORMATION
(CHILD/ADOLESCENT)

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name of Child *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Parents/Guardian(s) Mother:	Father:	**Are the parents living together**: Y/N
Previous Therapist:		**How did you hear about us?**

PERSONAL HEALTH HISTORY

Is the child under the care of a physician at this time? If so, Name:		Specialization:
Mailing Address	Phone:	Cell:
Street	Email:	How do you prefer to be contacted?
City	Parent/Guardian Employer and Occupation:	Client (Child's) School:
Zip Code		

What brings you into my office today?

Please ask your child to contribute a few lines to this section. (For example: What do you think you would like to talk to Joel about?)

Hospitalizations for psychiatric care or substance abuse (list other major hospitalizations under "**other**"):

Year	Reason	Hospital
Other		

List your child's prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Dosage	Frequency Taken
Allergies to medications ?		

HEALTH HABITS AND PERSONAL SAFETY (ANSWERED BY OR ON BEHALF OF THE CHILD: LISTED AS "YOU")

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL ; MARK **N/A** FOR NOT APPLICABLE						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
N/A	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
N/A	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
N/A	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
N/A	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider (Pathways Counseling) about your risk of this illness?				☐ Yes	☐ No

MENTAL HEALTH USE SPACE TO ELABORATE IF NECCESARY (ANSWERED BY OR ON BEHALF OF THE CHILD: LISTED AS "YOU")

Are you in counseling voluntarily?	☐ Yes	☐ No
Do you split time between different homes (as in the vase of separation, divorce, or other)?	☐ Yes	☐ No
Is stress/anxiety/worry a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed/anxious/worried?	☐ Yes	☐ No

Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor? Describe your experience:	☐ Yes	☐ No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider (Pathways Counseling)?	☐ Yes	☐ No

FAMILY HEALTH HISTORY (OPTIONAL):
SOMETIMES FAMILY HEALTH HISTORY/CONDITIONS CONTRIBUTE TO THE STRESSORS OR TRIGGERS IN YOUR LIFE.

	AGE	SIGNIFICANT HEALTH (PHYSICAL OR MENTAL) PROBLEMS		AGE	SIGNIFICANT HEALTH (MENTAL OR PHYSICAL) PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother			N/A	☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Is there anything else you would like me to know about your child?

Emergency Contact (other than a parent/guardian in the event that a parent cannot be reached):

Name:	Relationship:
Contact Information (phone, email):	Does this person know that the child is in counseling?

Insurance Information

Carrier/Insurance Company:	ID # (or SS#) :
Subscriber Name and Birth date:	Are you planning to file for Social Security Disability? Y / N Describe/Status:

This is a page where your child is free to write or draw anything that s/he would like to convey to me (feelings, thoughts, goals, desires):