Pathway to Wellness
Community Clinic

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CHILD INTAKE INFORMATION - AGE 14 AND YOUNGER

PLEASE DO THIS FORM IN ADDITION TO THE PATIENT INTAKE PACKET

Thank you for seeking services for your child.
Completing this form as thoroughly as possible will help with your comprehensive evaluation.

Child's Name:	DOB:
Name of person completing form:	Date:
My Relationship to Child: ☐ Biological ☐ Adopted ☐ Foster ☐ Other:	

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like? What are your child's positive qualities, skills, strengths?

FAMILY HISTORY

The name of the child's biological parents:

Mother: _____ Father: _____

Who has legal guardianship of your child? _____

Does the child or any family member have a history of alcohol, tobacco, or drug problems? ☐ Yes ☐ No

If yes, please describe: _____

Has your child or any family member ever experienced any type of abuse? ☐ Yes ☐ No
(physical, sexual, emotional/verbal, cultural, mental)

If yes, please describe: _____

_____

What kind of discipline is used with the child? _____

Who is the primary disciplinarian? _____

Are there any family circumstances you would like us to be aware of? _____

SOCIAL RELATIONSHIPS/FRIENDS

1) Is your child socially: ☐ Outgoing ☐ Shy ☐ Depends on the situation
2) Has your child experienced any bullying? ☐ Yes ☐ No
3) Is your child involved in any organized social activities (e.g., sports, scouts, music)? ☐ Yes ☐ No
4) Does the child spend more time with: ☐ Same Age Children ☐ Older ☐ Younger ☐ Adults ☐ Alone
5) Child's hobbies and interests: _____

_____

EDUCATION HISTORY

What school does your child attend? _____

_____

Grade: _____ Teacher's Name: _____

What does your child's teacher(s) say about him/her? ___

_____

_____

_____

Behavior or Academic concerns? ☐ Yes ☐ No

Developmental delays or learning problems previously identified? ☐ Yes ☐ No

Any history of special education, extended tutoring, occupational therapy, or speech therapy ☐ Yes ☐ No

Has the child ever had:

☐ IEP (Individualized Ed. Program) ☐ 504 Plan ☐ Other

Has the child ever been placed outside of the home? (foster care, treatment center, etc.) ☐ Yes ☐ No

MEDICAL HISTORY

Did the mother have any problems during the pregnancy or at delivery? ☐ Yes ☐ No ☐ I don't know
If yes, please explain: _____

_____

Did the mother use tobacco, alcohol, drugs or medications during the pregnancy? ☐ Yes ☐ No ☐ I don't know
If yes, please explain: _____

_____

Has your child experienced any of the following medical problems? (check if apply)

☐ Allergies ☐ Head injury ☐ Meningitis
☐ Asthma ☐ Hearing Problems ☐ Seizures
☐ Convulsions ☐ High Fever ☐ Serious accident
☐ Eating Disorder ☐ Hospitalization ☐ Surgery
☐ Eye/Ear Problems ☐ Loss of Consciousness
☐ Other: _____

Explain if Necessary: _____

_____

_____

If you feel the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial, or ethnic identity, please explain below:

_____

_____

CURRENT/OTHER CONCERNS

Has your child ever made statements of wanting to hurt him/herself or someone else? ☐ Yes ☐ No
Has your child ever purposely hurt him/herself or another? ☐ Yes ☐ No
If yes to either question, please describe the situation: _____

_____

_____

Suicide Risk to Self: ☐ Denies ☐ Ideation ☐ Intent ☐ Plan ☐ Attempt

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or caretaker)? If yes, please explain: _____

_____

_____

What qualities have helped your child to succeed at overcoming difficulties in the past? Does your child agree that the problem that she or he is seeking help for is problematic? _____

_____

_____

How intense is your child's emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe: _____

_____

Overall, how much do the problems affect your child's ability to perform at school, get along with others, and perform daily tasks such as chores? (Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe: _____

_____

When did these problems start? What was going on in your child's life at that time? _____

_____

_____

What are some of the things that are currently stressful to your child and his/her family? _____

_____

_____

Do you have any other concerns about your child or your family that you have not mentioned yet? _____

_____

_____

TREATMENT GOALS

From your preceding list of your child's behavior and your family concerns, what behaviors do you want to see change FIRST? What attainable goals would you like to see reached and how will you know when these goals are accomplished?