PATHFINDERS
COUNSELING AND CONSULTING

INTAKE QUESTIONNAIRE

The information in this packet is confidential and protected under the privacy act of 1974.

To be used with children between the ages of 5 and 18.

INSTRUCTIONS: For children able to understand and write out answers independently: Parents/Guardians will complete part I and the child will complete part II.

For children unable to independently answer the questions: Parents/Guardians will complete part I. The provider will provide guidance regarding the completion of part II which may include leaving it blank or reading the questions aloud to the child and writing in the answers for him/her.

Part I

To be completed by the parent or guardian (Complete **ONE** per family if appropriate)

Date: _____

I. Demographics:

Name of parents/guardians: _____

Who is completing Part I of this form? _____

Address (Street Number and Street Name): _____

City: _____ State: _____ Zip: _____

Phone number: (_____)_____ Type: ☐ Work ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Alternate phone number: (_____)_____ Type: ☐ Work ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Email Address: _____ May we email you? ☐ Yes ☐ No

Please note: Email correspondence is not considered to be a confidential means of communication.

How were you referred to us? _____

II. Parent(s) / Guardian(s) Information

ANSWER THE FOLLOWING QUESTIONS REGARDING THE **MOTHER OR ONE OF THE PARENTS / GUARDIANS**

Name (First, Middle Initial, Last): _____

Gender: ☐ Male ☐ Female Birth Date: _____ Age: _____ Place of Birth: _____

Education:

	Level	Name of School	Degree	Year Completed
	High School		Diploma / GED	
	College		Associates / Bachelors	
	Graduate School		Masters / Doctoral Level	

Relationship to Child:
□ Biological □ Stepparent □ Foster / Adoptive □ Legal Guardian □ Other:

Check all that apply to the **mother or one of the guardians** currently:
□ Never Married □ Separated □ Divorced □ Remarried □ Widowed
□ Dating □ Married □ Common Law □ Domestic partnership

How long have you been in your current committed relationship (married, common law, domestic partnership)? _____

Describe your relationship with your spouse / partner? _____

How many times have you been married? _____

How many children do you have? _____ What are the ages / genders of the children? _____

_____

Describe your relationship with your children? _____

ANSWER THE FOLLOWING QUESTIONS REGARDING THE **FATHER OR THE OTHER PARENT / GUARDIAN**, if applicable

Name (First, Middle Initial, Last): _____

Gender: □ Male □ Female Birth Date: _____ Age: _____ Place of Birth: _____

Education:

	Level	Name of School	Degree	Year Completed
	High School		Diploma / GED	
	College		Associates / Bachelors	
	Graduate School		Masters / Doctoral Level	

Relationship to Child:
□ Biological □ Stepparent □ Foster / Adoptive □ Legal Guardian □ Other:

Check all that apply to the **mother or one of the guardians** currently:
□ Never Married □ Separated □ Divorced □ Remarried □ Widowed
□ Dating □ Married □ Common Law □ Domestic partnership

How long have you been in your current committed relationship (married, common law, domestic partnership)? _____

Describe your relationship with your spouse / partner? _____

How many times have you been married? _____

How many children do you have? _____ What are the ages / genders of the children? _____

_____

Describe your relationship with your children? _____

_____

_____

III. Family Information / History

List all children in the home

Name	Age	Problems or Diagnoses

List all other people living in the home

Name	Age	Relationship

Current stressors in the family: _____

_____

Continue to the next section and complete ONE for EACH child who will be evaluated in this clinic

I. Child's Information:

Patient's Name (First, Middle Initial, Last): _____

Gender: □ Male □ Female Birth Date: _____ Age: _____ Place of Birth: _____

Name of the individual with primary legal rights of the child: _____

Name of the individual with primary custodial rights of the child: _____

What issues/concerns would you like the therapist to address with your child? _____

_____

How long has this issue been a concern? _____

Why seek treatment now? _____

Has your child had difficulties like this before □ Yes □ No

If yes, please explain: _____

_____

What are your child's three greatest stressors?

1. _____
2. _____
3. _____

How does your child typically cope with stressors?

_____

_____

_____

Describe the relationship(s) of the child with others in the family / home:

_____

_____

_____

Other current treatment: _____

II. Child's Race / Ethnic Ancestry:

□ Asian □ Black □ Caucasian / White □ Hispanic / Latino(a)
□ Native American / Alaskan □ Pacific Islander □ Other _____

First Language: _____ Second Language: _____

Number of years child has been in an English-speaking home: _____

III. Child's Home Life:

Discipline

What do you use for discipline with this child? _____

Does it work? □ Yes □ No

Does it work for other children in home? □ Yes □ No

Is there consistency in discipline amongst parents/guardians/caretakers? □ Yes □ No

If no, please explain: _____

_____

_____

_____

Free Time

What does the child do in his/her free time: _____

How much time does the child spend:

Watching TV _____ Playing video games _____ On the computer _____

Does the child have a TV of his/her own? _____

What kind of TV shows or movies does the child like? _____

What kind of video / computer games does the child like? _____

IV. Child's Mental Health Treatment History:

Has the patient ever had outpatient treatment or therapy? □ Yes □ No

When and by whom: _____

What was the diagnosis? _____

Mental Health Hospitalizations □ Yes □ No

Date(s)	Reason	Outcome

Has the patient ever experienced a head injury or traumatic brain injury? □ Yes □ No Describe: _____

_____

Is the patient currently taking psychiatric medications? □ Yes □ No

Name of Medication	Reason	Dose

Does anyone in the patient's family have mental illness or an emotional difficulty? □ Yes □ No

Please specify: _____

Has the patient experienced or witnessed any of the following?

□ Physical abuse □ Sexual abuse □ Verbal abuse □ Psychological / Emotional abuse

V. SYMPTOMS / PROBLEMS

Indicate if your child has now or has ever had any problems for each of the following categories:

Behavioral / Emotional

	Past	Now	Never
Nightmares			
Behaves like the opposite sex			
Has to be "perfect"			
Picks at skin			
Bites nails			
Pulls out hair, eyebrows, or eyelashes			
Difficulty paying attention			
Sleeps too much			
Sleeps too little			
Difficulty falling asleep at night			
Difficult to wake up			
Wakes up during night			
Wets self during the day			
Wets the bed at night			
Soils self during the day			
Soils the bed at night			
Washes hands excessively			
Checks things, such as locks, repeatedly			
Uncontrollable impulses			
Complains of a lot of aches and pains			
Unusual / Inappropriate interest in sex			
Sees people or things that are not there			
Hears voices or noises that are not there			
Makes paranoid comments			

	Past	Now	Never
Sadness			
General unhappiness			
Loss of interest in activities			
Nervous or high strung			
Anxiety, fears			
Excessive worry			
Mood swings			
Irritability			
Aggression			
Loss of control when angry			
Inflexibility			
Grief/loss			
Concern about dirt, germs			
Weight gain			
Eating too much			
Weight loss			
Eating too little			
Excessive dieting			
Vomiting			
Using laxatives to control weight			
Weighing daily			
Fear of gaining weight			
Low energy, tiredness			

Academic / Educational

	Past	Now	Never
Sudden drop in grades			
Afraid of going to school			
Refuses to go to school			
Very good at memorizing things such as commercials, songs, nursery rhymes			
Doesn't pretend when playing			

	Past	Now	Never
Learning or academic problems			
Poor concentration			
Hyperactivity, impulsivity			
Tends to line toys or things up neatly			
Tends to play with the same things			

Suicidal Behaviors

	Past	Now	Never
Suicide threats			
Prepares to harm self			
Cuts or burns self			

	Past	Now	Never
Suicide gestures or attempts			
Threatens to harm self			
Researches suicide or death			

Sensory/Motor

	Past	Now	Never
Overly sensitive to odors, sounds, textures			
Seems to be in a world of his/her own			
Problem regulating body temperature			
Repeats certain acts over and over			
Dislikes having hair washed			
Dislikes having face washed			
Prefers certain textures of clothes			
Bothered by tags in clothes			
Overly sensitive to pain			
Sudden, rapid, non-rhythmic movements:			
Blinking			
Head jerking			
Shoulder shrugging			
Touching			
Jumping			
Sudden, recurrent vocalizations:			
Barking			
Grunting			
Snorting			
Sniffing			
Words			
Phrases			

	Past	Now	Never
Putting things in mouth			
Coordination or clumsiness			
Rocking			
Headbanging			
Thumb-sucking			
Tantrums			
Poor eye contact			
Bedwetting after age 5			
Soiling after age 3			
Loss of previous abilities			
Flaps hands or arms when excited			
Sudden laughing			
Frequent throat clearing			
Spinning			
Grinding teeth			
Screaming spells			
Accident prone			
Walking on toes			
Drooling excessively			
Messy when eating			
Resists being touched			
Dislikes being held			
Irritable when held			
Troubles eating or swallowing			

Social / Relational	Past	Now	Never
Speech or language problems			
Clings to adults			
Lonely			
Demands a lot of attention			
Prefers to play alone			
Aggressive with other children			
Always wants to be in charge			
Bullied by others			
Bullying others			
Uses drugs			
Uses alcohol			
Uses tobacco			
Hangs around troubled kids			
Defiant, disrespectful			
Steals			
Swears			
Sets fires			
Runs away			

	Past	Now	Never
Family problems			
Parents arguing frequently			
Parents' pending divorce or separation			
Doesn't fit in with peers			
Lacks interest in others			
Doesn't share interests of other children			
Seen as "different" by other children			
Seems unaware of other children			
Doesn't participate in group activities			
Seems unaware of the needs / feelings of others			
Doesn't seek to share interests or enjoyment with others			
Problems with relationships			
Doesn't play well with other children			
Seems unable to recognize the use for social rules, such as politeness, greetings, farewells			
Sexually inappropriate behavior			

Check next to any of the items below have ever applied to your child:

Communication

- ☐ Talks to self
- ☐ Talks too much
- ☐ Talks just to talk
- ☐ Says bizarre things
- ☐ Says inappropriate things
- ☐ Repeats self
- ☐ Difficulty understanding humor
- ☐ Responds with a lot of giggles or nervous laughter when asked questions
- ☐ Speaks in long, rambling sentences
- ☐ Talks continually about a certain subject, even if people try to change the subject
- ☐ Does not respond to name
- ☐ Repeats what others say

VI. Child's Character Strengths:

Please check any of the following characteristics that you consider your child to have:

- ☐ Empathy
- ☐ Integrity
- ☐ Leadership
- ☐ Gratitude
- ☐ Love of learning
- ☐ Social intelligence
- ☐ Self-regulation / self-control
- ☐ Creativity
- ☐ Vitality
- ☐ Forgiveness / mercy
- ☐ Hope
- ☐ Perspective / wisdom
- ☐ Socially responsible / teamwork
- ☐ Appreciation of excellence / beauty
- ☐ Curiosity
- ☐ Love
- ☐ Humility / modesty
- ☐ Humor
- ☐ Bravery
- ☐ Fairness
- ☐ Open-mindedness
- ☐ Kindness
- ☐ Prudence
- ☐ Spirituality
- ☐ Persistence
- ☐ Intelligence

STOP HERE

Please have your child complete the next section if he/she is developmentally capable

Part II

The information in this packet is confidential and protected under the privacy act of 1974.

To be completed by **THE PATIENT**, if developmentally capable

Patient's Name (First, Middle Initial, Last): _____

Date of Birth: _____

I. Social History:

Who do you normally live with? Check all that apply:
□ Biological parents □ Adoptive parents □ Stepparents □ Siblings □ Grandparents □ Relatives □ Others

Overall, how would you describe your life? Check all that apply:
□ Happy □ Uneventful □ Unhappy □ Hard to remember □ Frightening
□ Other: _____

Are you experiencing any of the following? (***If you are not sure if you are experiencing these types of abuse, please ask your mental health provider.)***
□ Physical abuse □ Sexual abuse □ Verbal abuse □ Psychological / Emotional abuse

Does anything happen at home that makes you feel uncomfortable? □ Yes □ No

If so, what happens? _____

II. Education:

What grade are you in? _____

What school do you go to? _____

How would you describe your academic performance?
□ Excellent (A's and B's) □ Good (B's) □ High average (B's and C's) □ Average (C's) □ Poor (C's, D's, and F's)

Check all that apply to you at school:
□ No problems □ Difficulty concentrating □ Difficulty with teachers/staff
□ Academic problems □ Behavioral problems □ Learning disabilities

Do you like school? □ Yes □ No

Do you participate in sports or band? □ Yes □ No

III. Legal History:

Have you ever been in jail/prison? □ Yes □ No

Are you currently on probation or parole, or awaiting a pending court case? □ Yes □ No

Prior and current charges/arrests (please list reasons and provide dates): _____

_____

IV. Employment History:

Do you have a paying job? □ Yes □ No

If yes, describe your job: _____

If no, skip to "V. Leisure/Social Functioning" on the next page

Do you enjoy your work? □ Yes □ No

What is stressful about your current job? _____

Check all that applied during your employment. I had problems with:

□ No problems □ With supervisors □ Difficulty following rules
□ With coworkers □ With customers □ Difficulty controlling temper

V. Leisure/Social Functioning

Which of these do you enjoy doing in your free time?

□ Playing sports □ Reading □ Playing on the computer □ Playing video games □ Shopping
□ Motorcycles/Racing □ Talking with friends □ Exercising □ _____

Are you currently doing these things? □ Yes □ No

VI. Substance Use History

Have you ever had alcohol? □ Yes □ No

On average, how many days per week do you currently use alcohol? (Please put N/A if you do not drink): _____

On average, how many drinks do you have at a time? (Please put N/A if you do not drink): _____

What is your drink of choice when you drink? (Please put N/A if you do not drink): _____

Have you ever used illicit / illegal drugs or misused prescription medications? □ Yes □ No

Do you currently use illicit / illegal drugs or misuse prescription medications? □ Yes □ No

What type(s) of drugs do you use? (Please put N/A if you do not use drugs) _____

What is the approximate date of your last use of illicit drugs? (Please put N/A if you do not use drugs) _____

Are you concerned about your current drinking or drug use? □ Yes □ No

Have you ever received substance abuse treatment? □ Yes □ No

If so, please list where you received treatment, and when this occurred: _____

_____

Do you use tobacco products? □ Yes □ No If yes, what type? _____

How much do you use per day? (Please put N/A if you do not use tobacco products) _____

VII. Mental Health History:

Have you ever had outpatient treatment or therapy? □ Yes □ No

When were you treated, and by whom: _____

What was the diagnosis? _____

Have you ever been hospitalized in a psychiatric unit or psychiatric hospital? □ Yes □ No

When and where: _____

Have you ever experienced a head injury or traumatic brain injury? □ Yes □ No Describe: _____

_____

Are you currently taking medications for mood, attention, or other psychiatric condition? ☐ Yes ☐ No

Name of Medication	Reason	Dose

Does anyone in your family have mental illness or an emotional difficulty? ☐ Yes ☐ No

Please specify: _____

Have you ever intentionally harmed yourself without wanting to kill yourself (e.g., cutting, burning, etc.)? ☐ Yes ☐ No

If yes, when was the last time? _____

Are you feeling helpless or hopeless? ☐ Yes ☐ No

Do you have CURRENT thoughts of suicide or self-harm? ☐ Yes ☐ No

Do you have a specific plan or intent to hurt yourself currently? ☐ Yes ☐ No

Have you ever had suicidal thoughts or attempted suicide? ☐ Yes ☐ No

If yes, please list the date this occurred, and describe the circumstances: _____

_____

Do you have CURRENT thoughts about homicide or hurting someone else? ☐ Yes ☐ No

If yes, do you have a specific plan or intent to harm someone else? ☐ Yes ☐ No

VIII. Medical History:

Current medical problems, surgeries, or illnesses and date of onset:

_____

_____

Do you have chronic pain? ☐ Yes ☐ No

IX. Current Symptoms / Problems:

Check all that have applied to you in **the past 30 days**:

□ Sad mood	□ Racing thoughts	□ Abuse: Physical, Emotional, or Sexual
□ Loss of interest in activities	□ Risky behaviors	□ Seeing people, animals, or things that others cannot see or say are not there
□ Feelings of guilt	□ Gambling	□ Hearing voices or noises that others cannot hear or say are not there
□ Low energy, tiredness	□ Increased self-esteem	□ Feeling as if people are following you or watching you
□ Poor concentration	□ Decreased need for sleep / staying awake for several days	□ Problems in school or work
□ Changes in appetite	□ Unusual increase in energy / activity □ Trauma	□ Problems with relationships
□ Failure to thrive	□ Avoiding others	□ Parents' pending divorce or separation
□ Weight gain (_____ lbs)	□ Repeated, unwanted thoughts / images	□ Parents arguing frequently
□ Weight loss (_____lbs)	□ Flashbacks: _____ per week / month	□ Extreme calorie restriction / counting
□ Difficulty falling asleep	□ Nightmares: _____ per week / month	□ Self-induced vomiting
□ Difficulty staying asleep	□ Memory problems	□ Using laxatives to control weight
□ Unable to return to sleep	□ Panic or anxiety attacks	□ Weighing yourself daily
□ Decreased thoughts about sex	□ Anxiety in social or performance situations	□ Troubles eating or swallowing
□ Increased thoughts about sex	□ Uncontrollable impulses	□ Fear of gaining weight
□ Grief/sense of loss	□ Repetitive behaviors / rituals	□ Being bullied
□ Excessive worry	□ Health problems	□ Bullying others
□ Rapid mood swings	□ Chronic pain	
□ Irritability		
□ Frequent anger outbursts		

X. Personal Strengths:

Please check any of the following characteristics that you consider to be your strengths:

□ Empathy	□ Creativity	□ Curiosity	□ Open-mindedness
□ Integrity	□ Vitality	□ Love	□ Kindness
□ Leadership	□ Forgiveness / mercy	□ Humility / modesty	□ Prudence
□ Gratitude	□ Hope	□ Humor	□ Spirituality
□ Love of learning	□ Perspective / wisdom	□ Bravery	□ Persistence
□ Social intelligence	□ Socially responsible / teamwork	□ Fairness	
□ Self-regulation / self-control	□ Appreciation of excellence / beauty		

XI. Support:

Please check any of the following you consider to be a source of support:

□ Boyfriend / Girlfriend	□ Parents / Guardians	□ Siblings	□ Close Friend
□ Extended Family (e.g., grandparents)	□ Group of Friends	□ Church / Synagogue / Mosque / Temple	

Your provider may want you to complete additional questionnaires to further assess your symptoms.

Any additional questionnaires may be used to track your progress in treatment.

CHILD / ADOLESCENT INTAKE QUESTIONNAIRE
PSYCHIATRY ADDENDUM

The information in this packet is confidential and protected under the Privacy Act of 1974.

To be used with children.

INSTRUCTIONS: This portion of the packet is to be completed by the parents/guardians of each child prior to beginning psychiatric care.

I. Prenatal Information:

Answer the following questions regarding the **BIOLOGICAL MOTHER:**

Mother's age at the time of conception?			
Mother's age at time of delivery?			
			Comments
Was the mother ill during pregnancy?	Yes	No	
Had the mother had any prior miscarriages?	Yes	No	
Was the pregnancy planned?	Yes	No	
Did the mother receive any prenatal care?	Yes	No	
Was prenatal care delivered throughout the pregnancy?	Yes	No	
Did the mother take medications during the pregnancy?	Yes	No	

Were any of the following used before the pregnancy was known or during the pregnancy?

Vitamins	Yes	No	Which ones? Dose?
Supplements	Yes	No	Which ones? Dose?
Alcohol	Yes	No	How much/often
Drugs	Yes	No	Which drugs/how often
Cigarettes/tobacco	Yes	No	How much/often

Answer the following questions regarding the **BIOLOGICAL FATHER:**

Father's age at the time of conception?	
Father's age at delivery?	

Answer the following questions about the pregnancy and birth of **THIS CHILD:**

	Yes	No			
Were there any placental problems?					
Was the baby active during the pregnancy?	❒	❒			
How was the baby delivered (circle all that apply):	Vaginal		Forceps	Vacuum	Cesarean
At how many weeks was the baby delivered?					
Was the baby premature?	❒	❒			
Baby's birthweight					
Was the baby born in a hospital?	❒	❒	If not, where?		
How many days was the baby kept in the hospital after delivery?					
Was the child released from care facility at same time as mother?	❒	❒			
Was the child ever in the neonatal intensive care unit?	❒	❒	If yes, how long?		
Did the baby have trouble breathing?	❒	❒			
Were any birth injuries noted?	❒	❒			
Was the baby blue or jaundiced?	❒	❒			
Meconium aspiration?	❒	❒			
Meconium staining of amniotic fluid?	❒	❒			
Breech delivery?	❒	❒			
Rh incompatibility?	❒	❒			
Cord around neck?	❒	❒			
Breathing problems?	❒	❒			
Need for oxygen?	❒	❒			
Failure to thrive / progress?	❒	❒			
Fetal distress?	❒	❒			
Maternal complications?	❒	❒			
Cord around neck?	❒	❒			
Seizures?	❒	❒			
Infection?	❒	❒			
Twin birth?	❒	❒			
APGAR scores	At 1 minute:				At 5 minutes:

If the mother had any of the complications during pregnancy, please describe: _____

_____

_____

_____

_____

II. MEDICAL HISTORY

Surgeries

Date(s)	Reason	Outcome
	Ear tube(s)?	

Emergency Room Visits

Date(s)	Reason	Outcome

Medication allergies (Please list all medication allergies)

Indicate if your child has ever experienced the following with a check mark and date:

	Date		Date
❒ Lead ingestion/exposure	_____	❒ Head injuries	_____
❒ Date of last hearing test:	_____	❒ Loss of consciousness	_____
❒ Ear infections (number)	_____	❒ Seizures	_____
❒ Loud Snoring	_____	❒ Heart Disease	_____
❒ Heart murmur	_____		

III. DEVELOPMENTAL HISTORY

Milestones

Please indicate if your child met the following developmental milestones on time (please write in age if delayed):

	Normal	Delayed	If delayed, at what age was it achieved
Smiled (1-3 months)	❒	❒	
Rolled over (5 months)	❒	❒	
Fed self crackers (6 months)	❒	❒	
Sat without support (5-7 months)	❒	❒	
Crawled (6-10 months)	❒	❒	
Spoke first words (8-12 months)	❒	❒	
Stood without support (9-12 months)	❒	❒	
Walked without assistance (9-15 months)	❒	❒	
Scribbled (14 months)	❒	❒	
Pointed out body parts (15 months)	❒	❒	
Pointed to body parts (12-18 months)	❒	❒	
Said sentences (18-36 months)	❒	❒	
Said complete alphabet (18-48 months)	❒	❒	
Climbed stairs with rail (22 months)	❒	❒	
Named colors (24-36 months)	❒	❒	
Bladder trained (24-60 months)	❒	❒	
Bowel trained (36-60 months)	❒	❒	
Began to read (36-72 months)	❒	❒	
Pedaled tricycle (48-72 months)	❒	❒	
Pedaled bicycle (48-72 months)	❒	❒	
Buttoned clothing (48-60 months)	❒	❒	
Tied shoelaces (60-72 months)	❒	❒	

Place a check mark next to all of the items below that applied to your child **in the first 2 years** of life:

- ❒ Sleeping difficulties
- ❒ Rhythmic behaviors (rocking)
- ❒ Hard to comfort or console
- ❒ Floppiness (after 6 months)
- ❒ Stiffness
- ❒ Speech/language difficulties or delays
- ❒ Cried often and easily
- ❒ Not affectionate
- ❒ Poor eye contact
- ❒ Head banging
- ❒ Did not like being held

Gross/Fine Motor Coordination

Please rate your child's performance at the following skills:

	Good	Average	Poor
Walking	❒	❒	❒
Running	❒	❒	❒
Throwing	❒	❒	❒
Catching	❒	❒	❒
Shoelace tying	❒	❒	❒
Buttoning	❒	❒	❒
Writing	❒	❒	❒
Athletic abilities	❒	❒	❒

Comprehension and Understanding

Please rate your child at the following skills compared to other children of the same age:

	Above Average	Average	Below Average
Understanding directions	❒	❒	❒
Understanding situations	❒	❒	❒
Level of intelligence	❒	❒	❒

If below average, please explain: _____

_____

_____

Thank you for completing this questionnaire

Please complete any additional measures or turn in your paperwork to the front desk if complete.