



PATHWAY CLINIC



**PERSONAL INFORMATION SHEET**

Date: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Female or Male Marital Status: \_\_\_\_\_  
First Initial Last (circle one)

Address: \_\_\_\_\_  
Street/RFD/Apt./Box City, State, Zip

Home Phone: \_\_\_\_\_ ok to call  Yes  No Cell Phone: \_\_\_\_\_ ok to call  Yes  No

Work Phone: \_\_\_\_\_ ok to call  Yes  No Can we leave messages:  Yes  No

Emergency Contact Name & Phone #: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**INSURANCE OR PAYMENT INFORMATION (PRIMARY)**

Policy Holder: \_\_\_\_\_  
Name Address Home Phone

Relationship to Patient: \_\_\_\_\_ Resp. Person DOB \_\_\_\_\_ Resp. Person SS# \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Subscriber or ID #: \_\_\_\_\_

Group or DIV #: \_\_\_\_\_

**OTHER INSURANCE INFORMATION (SECONDARY)**

Name: \_\_\_\_\_  
Address Phone

Name of Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Above Named SS#: \_\_\_\_\_

Subscriber or ID #: \_\_\_\_\_ Group or DIV #: \_\_\_\_\_

**FAMILY DOCTOR**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Clinic/Hospital: \_\_\_\_\_

Please briefly describe why you or your child are seeking treatment : \_\_\_\_\_

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**PLEASE CHECK OFF ALL OF THE ITEMS BELOW THAT CURRENTLY APPLY OR HAVE APPLIED IN THE PAST:**

- Argues, talks back
- Body image issues
- Bullies, intimidates, provokes others
- Cheats
- Conflicts with parents
- Cruel to animals
- Complains/whines
- Compulsive behaviors: shopping / sexual behaviors / gambling / hair pulling / other \_\_\_\_\_
- Cries easily/frequently, feelings easily hurt
- Difficulties with parent's new partner/spouse/new family
- Dependent, immature, only younger friends
- Divorce/separation of your parents
- Divorce/separation from your significant other/spouse
- Drug or alcohol use
- Eating/food issues. Please circle: over eating, under eating, poor appetite, vomiting
- Fearful, afraid of new situations
- Fighting, violent, aggressive, destructive
- Fire setting
- Friendship issues
- Frequent complaints of illness
- Grief, loss
- Highly immersed in fantasy life, imaginary playmates
- Inattentive, distractible, poor concentration, slow to respond
- Incontinence, wetting or soiling self at day/nighttime
- Interrupts, talks out, yells
- Isolates, withdraws
- Lack of organization, unprepared
- Lacks respect for authority, insults, dares, provokes
- Learning disability
- Legal difficulties=truancy, vandalism, shoplifting, curfew
- Lying
- Low frustration tolerance, irritability
- Moody
- Nail biting, finger sucking, hair chewing, picking at things
- Nervous, anxiety, panic attacks
- Nightmares
- Overactive, restless, hyperactive, fidgety
- Oppositional refuses direction, non compliance
- Physical or sexual abuse, neglect
- Poor sibling relationship(s)
- Pouts

**SYMPTOMS CHECK LIST CONT'D**

- Procrastinates, wastes time
- Recent move, new school, loss of friends
- Rocking, head banging, or other repetitive movements
- Runs away
- Sad, unhappy, depressed
- School problems
- Self-harming behaviors-biting, hitting, cutting, burning self
- Sexual issues
- Shy, timid
- Shoplifting
- Sleep issues-too much, too little, frequent wake-ups
- Suicide talk or attempt
- Swearing, foul language, name calling
- Temper tantrums, rages
- Tics-involuntary movements, noises or word production
- Teased, picked on, bullied
- Truant, school avoidant
- Work avoidance

**\*\*\*Please go back over the symptom checklist and write #1, #2, and #3 next to the concerns for which you most want help.**

**FAMILY & SOCIAL HISTORY:**

(From the patient's perspective)

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

How many children are in your family of origin: \_\_\_\_\_ What number are you? \_\_\_\_\_

Siblings names and ages: \_\_\_\_\_

Do you have any children? If yes, provide names and ages: \_\_\_\_\_

Who currently lives in your household? \_\_\_\_\_

What is your highest grade level completed? \_\_\_\_\_

How did you do academically in school? \_\_\_\_\_

What is your current occupation/job? \_\_\_\_\_

Where do you work? \_\_\_\_\_ Have you ever been fired? Yes or No

Do you have any military history? Yes or No

If parents are separated/divorced, please briefly explain placement arrangement and parent's current level of co-parenting with one another: \_\_\_\_\_

Do you or does your child have any concerns relating to their ethnicity or religion? Yes or No If Yes, please explain: \_\_\_\_\_

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### **MEDICAL INFORMATION**

Who is your Primary Health Care provider (i.e. physician, nurse, OB/GYN)?: \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Did you have any significant problems? Yes / No

If yes, please identify: \_\_\_\_\_

Do you take over the counter drugs or vitamins regularly? Yes / No If yes, what are they? \_\_\_\_\_

Please list any current prescribed medication(s) and the dose(s): \_\_\_\_\_

Prescribed by whom: \_\_\_\_\_

Please list any previously prescribed medication(s) and the dose(s): \_\_\_\_\_

Prescribed by whom: \_\_\_\_\_

Were there any complications with pregnancy or delivery of your child? Yes / No / N/A

If yes, please explain: \_\_\_\_\_

Have you or your child had difficulties with any normal developmental milestones? (i.e. walking, talking)

If so, please list: \_\_\_\_\_

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### **MEDICAL CONCERNS**

**Please check any medical issues that apply:**

- |  |   |
|--|---|
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Headaches/migraines        |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Drug allergies             |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Head injury                |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Vision or hearing problems |
| <input type="checkbox"/> Chronic pain          | <input type="checkbox"/> Weight gain or loss        |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Frequent illness           |
| <input type="checkbox"/> Diarrhea/constipation | <input type="checkbox"/> Menstrual irregularities   |
| <input type="checkbox"/> Seizure disorder      | <input type="checkbox"/> Toileting issues           |
| <input type="checkbox"/> Heart problems        |   |

**PSYCHIATRIC HISTORY:**

(From the patient's perspective)

Have you ever received therapy/counseling before? Yes / No If yes, where? \_\_\_\_\_

Have you ever been prescribed psychiatric medication (i.e. antidepressant(s))? Yes / No

If yes, please list medication and describe the length of time taken and purpose: \_\_\_\_\_

Have you ever been hospitalized for psychiatric problems? Yes / No

If yes, please describe the reason/situation: \_\_\_\_\_

Do you have any personal history of suicide attempts? Yes / No

If yes, please describe the situation: \_\_\_\_\_

Has anyone in your family attempted or committed suicide? Yes / No

If yes, whom? \_\_\_\_\_

Have any of your family members had a problem(s) with any of the following?

If so, what is their relationship to you?

Yes- Depression: \_\_\_\_\_

Yes- Anxiety: \_\_\_\_\_

Yes- Eating Disorder(s): \_\_\_\_\_

Yes- Bipolar Disorder/Manic-depression: \_\_\_\_\_

Yes- Obsessive-compulsive disorder: \_\_\_\_\_

Yes- Alcohol/drug problems: \_\_\_\_\_

Yes- Suicide attempts: \_\_\_\_\_

Yes- Psychiatric hospitalizations: \_\_\_\_\_

Yes- Other mental health/psychiatric problems – please specify: \_\_\_\_\_

**CHEMICAL DEPENDENCY/ALCOHOL HISTORY:**

How often and how much do you drink alcoholic beverages?

Never \_\_\_\_\_

In a week: \_\_\_\_\_

In a month: \_\_\_\_\_

Per day: \_\_\_\_\_

Is there anything that was not covered in this form that you feel is important to make your therapist aware of?

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Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_