Blissful Path Therapy

Follow your bliss

CHILD INTAKE EVALUATION

Name: _____

Address: _____

City: _____ Zip: _____

Age: _____ Birthday: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

What school do you go to? _____ What grade are you in? _____

What is your favorite subject? _____

How is your overall health? OVery Good OGood OAverage OPoor Gender: OMale OFemale

Who is your Doctor? _____

When was the last time you visited the Doctor's office? _____

Are you currently under a Doctor's care? OYes ONo

For what condition? _____

Are you currently taking medication? OYes ONo

If so, what medication(s) and dosage? _____

_____

Where are you in the birth order? O Oldest O 2nd O 3rd O 4th O Youngest O Only

List your brothers and sisters in order of their age:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

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Who do you get along with best in your family?_____

Why? _____

_____

_____

Who is your best friend? _____

Do you play sports or have a hobby? If so, what? _____

_____

_____

Check any of the following that you have experienced in the last six months:

- ☐ Problems at School: Grades, Friends, Teachers, etc.
- ☐ Loss of Appetite
- ☐ Sleeplessness
- ☐ Withdrawn (Shy)
- ☐ Anger
- ☐ Guilt
- ☐ Recent Death of Family or Pet: _____
- ☐ Rage/Violence
- ☐ Loneliness
- ☐ Rebellion
- ☐ Depression
- ☐ Jealousy
- ☐ Problem with Mom
- ☐ Problem with Step-Mom
- ☐ Problem with Dad
- ☐ Problem with Step-Dad
- ☐ Fear
- ☐ Eating Difficulties
- ☐ Dishonesty
- ☐ Attention Deficit
- ☐ Suicidal Thoughts
- ☐ Other: _____

Client Signature: _____ Date: _____

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