PATHWAYS
PSYCHOLOGY, PLLC
Cristin M. Saffo, Psy.D.

www.pathwayspsych.net
2971 Crouse Lane, Suite A
Burlington, NC 27215
Office: (336) 524-1628
Fax: (336) 792-5896

PATIENT QUESTIONNAIRE
For Parents/Guardians of Minor Children

This questionnaire is designed to help us build a solid foundation for your child's therapy. By responding to these questions as thoroughly as you can, you will be:

- Providing me with relevant background information about your child.
- Helping me to get to know your child's history in a more efficient and effective way.
- Reducing the amount of time we will need to spend in sessions reviewing basic information.
- Assisting me in developing a plan for your child's therapy.

Some items on this questionnaire may not pertain to your child- please feel free to skip those. If you need additional space to answer any of the questions, please use the back of the page. If there is a question you do not wish to answer in writing, please leave it blank and we can discuss it in person.

This questionnaire, and your responses (whether verbal or in writing), will become part of your child's clinical file and will be kept confidential.

Patient Name _____ DOB _____

Year in School _____

Name of School _____

Current Household

Please list current household members (continue on back if needed):

Name	Age	Relationship to your child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Members

Is your child close with other family members who do not live with you (grandparents, aunts/uncles, siblings, cousins, etc.)? Y _____ N _____
If yes, please list below: (continue on back if needed)

Name	Age	Relationship to your child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Academic History

Please provide a brief summary of your child's academic performance (including information about any IEPs or 504 plans):

_____

_____

_____

Please provide a brief summary of any school-related problems (attendance/tardiness issues, bullying or being bullied, disciplinary issues, detentions and/or suspensions, etc.):

_____

_____

_____

Any other information you'd like me to know regarding your child's school history:

_____

_____

Psychological History

Has your child attended therapy in the past? If so, please provide a brief summary:

_____

_____

_____

Is your child currently taking any psychiatric medications? Y _____ N _____
If yes, please list below:

Medication	Dosage	Prescribing Doctor	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child had any psychiatric hospitalizations? Y _____ N _____
If yes, please list below (dates can be approximate; use back if needed):

Date(s)	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

Is there a family history of any psychological disturbance or treatment (including depression, anxiety, mania, hallucinations, psychosis, nervous breakdown, suicide, or any other emotional disturbance)? If so, please describe: (please note, addictive behaviors are addressed in a later section)

_____

_____

_____

_____

_____

Developmental History

Were there any complications during pregnancy? If yes, please describe:

_____

_____

_____

Please describe whether your child met key developmental milestones (crawling, walking, motor movements, speech, toileting, etc.) within expected time frames, and note any significant delays:

_____

_____

_____

_____

_____

Medical History

Has your child had a physical exam within the last year? Y _____ N _____

Does your child have any drug allergies? Y _____ N _____ If yes, please describe:

_____

Does your child have any serious medical concerns or severe allergies? If so, please describe (use back if needed):

_____

_____

_____

Is your child currently taking any medications for medical (non-psychiatric) reasons? Y _____ N ____
If yes, please list below:

Medication	Dosage	Prescribing Doctor	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child had any medical hospitalizations? Y _____ N _____
If yes, please list below (dates can be approximate; use back if needed):

Date(s)	Hospital	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

Is there a family history of any major medical and/or hereditary issues (including cancer, heart attack or disease, stroke, seizures, diabetes, thyroid problems, dementia, Parkinson's, Alzheimer's, autoimmune disease)? If so, please describe:

_____

_____

_____

_____

Alcohol, Substance Use, and Addiction History

Does your child currently drink alcohol? Y _____ N _____ If yes, please describe amount and frequency (if known):

_____

_____

Does your child currently use any recreational drugs (including marijuana), or medications not prescribed for him/her? Y _____ N _____
If yes, please describe amount and frequency (if known):

_____

_____

Is there any family history of problems with alcohol use, substance use, or addictive behaviors? If so, please describe:

_____

_____

_____

Significant Life Events

Are there any other experiences or life events that your child has experienced that you'd like to tell me about- experiences that were formative in shaping who your child is today, and which would help me to know your child better? (These could include both positive and more difficult events, such as accomplishments, awards, sports/activities, volunteer work, losses, trauma, transitions, moves, etc.)

_____

_____

_____

_____

_____

_____

_____

Support System/Network

Please describe who and what your child can rely on for support in his/her life (family, friends, pets, hobbies, spiritual/religious beliefs, church or community involvement, activities, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

Revised July 2018