Adolescent Intake Assessment

(to be completed by parent/guardian)

Please provide the following information in preparation for your interview with your child's mental health clinician.

DATE:

CHILD'S NAME (FIRST, LAST):

CHILD'S DOB/AGE:

CHILD'S GENDER: ☐ Female ☐ Male ☐ Other: _____
PREFERRED PRONOUNS: ☐ She/Her ☐ He/Him ☐ Other: _____

CHILD'S PHONE NUMBER: _____
OK to leave VM ☐ YES ☐ NO
OK to text ☐ YES ☐ NO
Child's Email: _____
OK to send email ☐ YES ☐ NO
*please note: email correspondence is not considered to be a confidential means of communication

CHILD'S LEVEL OF EDUCATION: ☐ Elementary School
☐ Middle School
☐ High School
☐ GED
☐ Other: _____
NAME OF CHILD'S SCHOOL: _____
CHILD'S PLACE OF EMPLOYMENT: _____

5 WORDS TO DESCRIBE YOUR CHILD: _____
_____
_____

3 OF YOUR CHILD'S STRENGTHS: _____
_____
_____

Emergency Contact (name and phone number): _____
Hospital Preference: _____

Parent/Guardian Name: _____
Phone: _____
OK to leave VM ☐ YES ☐ NO
OK to text ☐ YES ☐ NO
Email: _____
OK to send email ☐ YES ☐ NO
*please note: email correspondence is not considered to be a confidential means of communication

Parent/Guardian Name: _____
Phone: _____
OK to leave VM ☐ YES ☐ NO
OK to text ☐ YES ☐ NO
Email: _____
OK to send email ☐ YES ☐ NO
*please note: email correspondence is not considered to be a confidential means of communication

REASON FOR BRINGING YOUR CHILD HERE TODAY:

Living Situation

Parent's Home	**Residential Care/Treatment Facility****	**Other****
☐ RENT ☐ OWN	☐ HOSPITAL ☐ TEMPORARY HOUSING ☐ RESIDENTIAL CARE ☐ NURSING HOME	☐ FRIEND'S HOME ☐ RELATIVE'S HOME ☐ HOMELESS

****IDENTIFY PERSON'S NAME OR FACILITY:**

Primary Household

Household member name	Relationship to child	Age	Job/school	Highest level of education	Quality of relationship

STREET ADDRESS:

Does the client live in more than one household?
☐ **NO** If no, skip to "Additional Family Members" ☐ **YES** If yes, complete the "Secondary Household" information below.

Secondary Household

Household member name	Relationship to child	Age	Job/school	Highest level of education	Quality of relationship

STREET ADDRESS:

Family members who live in both households:
☐ ONLY CHILD
☐ CHILD and (list): _____

Additional family members:
☐ NO parents or sibling(s) other than those listed in Primary or Secondary Households
☐ YES, please list family members: _____

Custody and parenting plan:
☐ LIVES WITH BOTH PARENTS (biological or adoptive) in same household
☐ SINGLE PARENT
☐ SHARED CUSTODY - parents in different households
☐ OTHER (describe): _____

Development

Have you ever had concerns about the following for this child?

Pregnancy	Yes	No	Unknown
Had bleeding	☐	☐	☐
Had toxemia	☐	☐	☐
Got injured or hurt	☐	☐	☐
Took illicit drugs and/or drank alcohol	☐	☐	☐
Had an infection	☐	☐	☐
Smoked during pregnancy	☐	☐	☐
Length of pregnancy: _____ months			☐
Other pregnancy problems/Illnesses/concerns Specify: _____ _____	☐	☐	☐

Birth/Early Infancy	Yes	No	Unknown
Born prematurely	☐	☐	☐
Injury at birth	☐	☐	☐
Had trouble breathing and/or needed oxygen	☐	☐	☐
Was a twin or triplet	☐	☐	☐
Had an infection	☐	☐	☐
Had seizures (fits, convulsions)	☐	☐	☐
Was very jittery	☐	☐	☐

Childhood Health	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Seizures (convulsions) or spells	☐	☐	☐		☐
High fever	☐	☐	☐		☐
Head injury	☐	☐	☐		☐

Asthma	☐	☐	☐		☐
Trouble with hearing	☐	☐	☐		☐
Trouble with vision	☐	☐	☐		☐
Poisoning or overdose	☐	☐	☐		☐
Serious illness	☐	☐	☐		☐
Hospitalization	☐	☐	☐		☐
Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Poor appetite	☐	☐	☐		☐
Constipation	☐	☐	☐		☐
Stomach aches	☐	☐	☐		☐
Trouble falling asleep	☐	☐	☐		☐
Trouble staying asleep	☐	☐	☐		☐
Overactivity	☐	☐	☐		☐
Head banging	☐	☐	☐		☐
Rocking in bed	☐	☐	☐		☐
Self-destructive behavior	☐	☐	☐		☐
Difficulty in being comforted or consoled	☐	☐	☐		☐
Stiffness or rigidity	☐	☐	☐		☐
Looseness or floppiness	☐	☐	☐		☐
Crying often and easily	☐	☐	☐		☐
Shyness	☐	☐	☐		☐
Irritability	☐	☐	☐		☐
Extreme reaction to noise or sudden movement	☐	☐	☐		☐
Attention	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Can concentrate for only a short time unless things are very interesting	☐	☐	☐		☐
Understands the main ideas of things but misses important details	☐	☐	☐		☐

Does work or performs many tasks carelessly without thinking	☐	☐	☐		☐
Learns a new skill well one day and then can't seem to do it a few days later	☐	☐	☐		☐
Receives very unpredictable (inconsistent) grades or test scores in school	☐	☐	☐		☐
Can work well only on things they really enjoy doing or thinking about	☐	☐	☐		☐
Often doesn't notice when they make mistakes	☐	☐	☐		☐
Seems not to realize when they are disturbing someone	☐	☐	☐		☐
Doesn't do much better after punishment or correction	☐	☐	☐		☐
Makes comments about or is distracted by background noises or unimportant things	☐	☐	☐		☐
Seems to want things right away and/or is hard to satisfy	☐	☐	☐		☐
Annoys or bothers other children	☐	☐	☐		☐
Behavior is hard to predict	☐	☐	☐		☐
Bullies others	☐	☐	☐		☐
Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occuring?
Has bad dreams	☐	☐	☐		☐
Is often very quiet or withdrawn	☐	☐	☐		☐
Is often down on self	☐	☐	☐		☐
Is often tired	☐	☐	☐		☐
Speaks unclearly, stutters, or stammers	☐	☐	☐		☐
Wets bed or pants often	☐	☐	☐		☐
Soils underwear or has accidents with bowel movements	☐	☐	☐		☐
Is often too neat or orderly	☐	☐	☐		☐
Is often too concerned about cleanliness	☐	☐	☐		☐
Often plays with matches	☐	☐	☐		☐
Destroys objects at home	☐	☐	☐		☐

Destroys objects away from home	☐	☐	☐		☐
Is fearless	☐	☐	☐		☐
Is cruel to animals	☐	☐	☐		☐
Is not liked by other children	☐	☐	☐		☐
Feels ill on school mornings	☐	☐	☐		☐
Has eating problems (overeats or undereats)	☐	☐	☐		☐
Is preoccupied with food or diet	☐	☐	☐		☐
Is part of a clique or gang that causes trouble	☐	☐	☐		☐
Other behaviors not noted above	☐	☐	☐		☐
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	☐	☐	☐		☐
Have you ever had concerns about your child's sexual arousal development or behaviors?	☐	☐	☐		☐

IF THERE ARE INDICATIONS OF PROBLEMS, PLEASE EXPLAIN:

_____
_____
_____
_____
_____
_____
_____

Child's School Functioning

Educational Classification

Does your child receive special education services? ☐ YES ☐ NO

If no, has your child ever been tested and determined not to need services? ☐ YES ☐ NO

Typical education classroom, no special services? ☐ YES ☐ NO

If no, check all that apply below.

- ☐ Early childhood special ed/developmental delay
- ☐ Autism Spectrum Disorder
- ☐ Traumatic brain injury
- ☐ Other health impaired
- ☐ Physically impaired
- ☐ Developmental disability
- ☐ Learning disability
- ☐ Cognitive disability
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Speech or language impaired
- ☐ Emotional/behavior disorder
- ☐ Unsure
- ☐ Other: _____

COMMENTS ON EDUCATIONAL CLASSIFICATION:

_____
_____
_____

Child's Legal History

Does your child have a history of legal charges? ☐ YES ☐ NO

IF YES, DESCRIBE CHARGES:

_____

_____

Is your child currently on probation? ☐ YES ☐ NO Has your child ever been on probation? ☐ YES ☐ NO

Has your child ever been court ordered in to substance abuse or mental health treatment? ☐ YES ☐ NO

Child's Trauma History

Children's Protective Services (CPS) involvement with the family? ☐ YES ☐ NO

IF YES, DESCRIBE:

_____

_____

NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE):

☐ NONE REPORTED

NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED ADVOCATE (CASA) ASSIGNED TO FAMILY:

☐ NONE REPORTED

Has your child ever experienced any of the following?

☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse ☐ Sexual/physical assault ☐ Neglect
☐ Witnessed abuse ☐ Witnessed domestic violence ☐ Community violence ☐ Bullied
☐ Any significant loss ☐ Suicide attempt ☐ Major illness ☐ Major accident/injury ☐ Natural disaster
☐ Other: _____

Child's Mental Health Treatment History

Does your child have a mental health diagnosis? ☐ NO ☐ YES If yes, include diagnosis here: _____

Previous mental health treatment ☐ NO ☐ YES If yes, please list reason for treatment and dates:

Reason	Dates

Currently on any medication(s)? ☐ YES ☐ NO

IF YES, PLEASE LIST MEDICATION(s) (name, dosage, frequency):

PRIMARY CARE PHYSICIAN:	PHONE NUMBER:

ADDRESS:	FAX NUMBER:
OTHER PRESCRIBING PHYSICIAN(S):	PHONE NUMBER(S):
ADDRESS:	FAX NUMBER(S):

Child's Substance Use History

Do you have any concerns about your child's use of alcohol or drugs? ☐ YES ☐ NO
Do you have any other issues or concerns about your child that you would like to have addressed? ☐ YES ☐ NO
COMMENTS: _____ _____ _____

Family Environment/Relationships

Please indicate the best descriptions of parent-child relationships below.

Parent-Child (Client) Relationship(s) P = Primary Household S = Secondary Household B = Both					
Parent-child conflict	____ NONE-MILD	____ MODERATE	____ SEVERE		
Issues with supervision and monitoring of child	____ ALWAYS	____ USUALLY	____ INCONSISTENTLY	____ RARELY	
Cooperation between parents regarding child-rearing	____ ALWAYS	____ USUALLY	____ INCONSISTENTLY	____ RARELY	___ N/A
Parent positive activities with child	____ FREQUENT	____ OCCASIONAL	____ INFREQUENT		
Parent satisfaction with relationship	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED		
Child satisfaction with relationship	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED		
COMMENTS: _____ _____ _____					

Please indicate the best descriptions of sibling-child relationships below.

Sibling-Child (Client) Relationship(s) ☐ NO SIBLINGS P = Primary Household S = Secondary Household B = Both			
Child-sibling conflict	____ NONE-MILD	____ MODERATE	____ SEVERE

Sibling(s) positive activities with child	____ FREQUENT	____ OCCASIONAL	____ INFREQUENT
Sibling(s) satisfaction with relationship	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED
Child satisfaction with relationship(s)	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED
COMMENTS: _____ _____ _____			

Please indicate the best descriptions of parent marital or couple relationships below.

Parent Marital or Couple Relationship(s) ☐ NOT APPLICABLE P = Primary Household S = Secondary Household B = Both			
Marital or couple conflict	____ NONE-MILD	____ MODERATE	____ SEVERE
Marital or couple satisfaction	____ SATISFIED	____ NEUTRAL	____ DISSATISFIED
COMMENTS: _____ _____			

Other Family Concerns			If yes, indicate:		
	NO	**YES**	Parent	Sibling	Other
Family member health problem	☐	☐			
Family member disability	☐	☐			
Family member legal issues	☐	☐			
Family financial concerns	☐	☐			
Family member alcohol abuse	☐	☐			
Family member substance abuse	☐	☐			
Family member anxiety	☐	☐			
Family member depression	☐	☐			
Family member mania	☐	☐			
Family member schizophrenia/other psychosis	☐	☐			
Significant family stressors (moves, deaths, divorce, loss of employment)	☐	☐			
COMMENTS ON OTHER FAMILY CONCERNS: _____ _____					