



CHILD & ADOLESCENT INTAKE

General Instructions

Please fill out these forms as fully and openly as possible. This information is helpful to ensure an accurate assessment, which will assist us in making appropriate diagnostic decisions and recommendations. Please feel free to attach any additional information that you think might help us better understand the child/adolescent (i.e., past psychological reports, etc.). We appreciate your cooperation and willingness to complete these forms prior to the initial appointment.

When completing these forms, please consider the following:

- Please read the questions carefully and answer them in full. Please ask for clarification if you do not understand an item.
- Write as legibly as possible.
- The child/adolescent's parent/guardian and/or the child/adolescent should complete the forms.
- Please understand that this information is for evaluation, intervention, and recommendation purposes. The information you provide will be part of the evaluation. If there are specific details that you are hesitant in sharing, please bring these issues to our attention during your appointment.

Thank you in advance for completing these forms.

Child, Youth & Family Mental Wellness



CHILD & ADOLESCENT INTAKE

CLIENT NAME/DOB/MRN
(or affix label)

DATE

General Information

INFORMATION REGARDING THE INDIVIDUAL COMPLETING THIS FORM			
Who is giving this information? <input type="checkbox"/> CHILD/ADOLESCENT <input type="checkbox"/> PARENT/GUARDIAN/CAREGIVER <input type="checkbox"/> BOTH			
FULL NAME		RELATIONSHIP TO CHILD	
FULL NAME		RELATIONSHIP TO CHILD	
CHILD/ADOLESCENT (CLIENT) INFORMATION			
FIRST NAME	MIDDLE NAME	LAST NAME	NICKNAME/PREFERRED NAME
DATE OF BIRTH	AGE	SEX ASSIGNED AT BIRTH <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> DECLINE TO ANSWER	
CURRENT GENDER			
<input type="checkbox"/> FEMALE	<input type="checkbox"/> TRANSGENDER FEMALE	<input type="checkbox"/> DECLINE TO ANSWER	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> MALE	<input type="checkbox"/> TRANSGENDER MALE	<input type="checkbox"/> GENDER QUEER/NON-BINARY	_____
PREFERRED PRONOUNS			
<input type="checkbox"/> SHE/HER/HERS	<input type="checkbox"/> THEY/THEM/THEIRS	<input type="checkbox"/> DECLINE TO ANSWER	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> HE/HIM/HIS	<input type="checkbox"/> CHILD/ADOLESCENT'S NAME		_____

Presenting Issues and Goals

PRESENTING ISSUES											
What brings you here today? Who or what prompted you to seek services? (include symptoms, precipitating events or referrals)											
How severe, on a scale of 1-10 (with 10 being the most severe), do you rate the child/adolescent's presenting problem (stated above)? (select one)											
LEAST SEVERE	1	2	3	4	5	6	7	8	9	10	MOST SEVERE
How long has this problem/these problems been causing the child/adolescent distress?											
<input type="checkbox"/> LESS THAN 1 MONTH			<input type="checkbox"/> 1-6 MONTHS			<input type="checkbox"/> 6 MONTHS – 1 YEAR			<input type="checkbox"/> LONGER THAN 1 YEAR		
What areas of functioning is this problem/difficulty affecting?											
<input type="checkbox"/> BASIC NEEDS/SELF CARE			<input type="checkbox"/> HOBBIES			<input type="checkbox"/> SCHOOL/LEARNING (achievement, behavior, attendance)			<input type="checkbox"/> SLEEP		
<input type="checkbox"/> CRIME/DELINQUENCY			<input type="checkbox"/> HOME/LIVING SITUATION						<input type="checkbox"/> WORK		
<input type="checkbox"/> FAMILY/RELATIONSHIPS			<input type="checkbox"/> PHYSICAL/MEDICAL			<input type="checkbox"/> SEXUAL DEVELOPMENT			<input type="checkbox"/> OTHER: _____		
GOALS FOR SERVICES											
What are the goals for mental health services?											
How will you know when services are complete?											
Are there any needs (physical abilities, cultural, religion) related to the child/adolescent's care that will help us work together better with them and your family? If so, please explain.											



Child's Behavioral Health History & Adverse Events

MOOD				
CURRENT MOOD-RELATED SYMPTOMS/DIFFICULTIES	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Have they been feeling sad, blue, down, depressed, or irritable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If so, does feeling this way make it hard for your child to do things, to concentrate, or to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seems angry most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ADVERSE EVENTS				
CURRENT/PAST STRESSFUL OR SCARY EVENTS	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Repeatedly been told they are no good, yelled at in a scary way, or had someone threaten to abandon, leave or send them away?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gone through a period when they lacked appropriate care (e.g., not having enough to eat/drink, lacking shelter, left alone when they were too young, left with a caregiver who was abusing drugs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Been separated from their parent/caregiver for more than a few days OR under very stressful circumstances (e.g., due to foster care, major illness, hospitalization)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Did anyone ever touch them in their private parts when they shouldn't have? Or forced/pressured the child/adolescent to do sexual things (e.g., undress, touch someone else's private parts)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Been physically hurt by someone (e.g., hit, pushed, choked, shaken, bit, burned)? Or punished in a way that caused physical injury or bruises? Or attacked with a weapon (e.g., gun, knife)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has your child ever experienced or witnessed an event in which they were seriously injured or their life was in danger or they thought they were going to be seriously injured or endangered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a history of Child Protective Services (CPS) and/or Indian Child Welfare (ICW) (e.g., beda?chelh) involvement with family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SUBSTANCE USE & GAMBLING				
CURRENT/PAST SUBSTANCE USE (WITHIN LAST ONE YEAR)	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CURRENT/PAST GAMBLING CONCERNS	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Any concerns about their gambling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Your clinician may request that you complete additional measures to provide further information about symptoms or behavioral concerns.</i>				



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(or affix label)

Child's Behavioral Health Treatment History

MENTAL HEALTH				
CURRENT/PAST SERVICES	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Been diagnosed with a mental health, emotional, or psychological condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis given, when, by whom:
Had any emergency room visits for emotional or behavioral problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reason, date, outcome, and name of hospital:
Had mental health treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please complete table below.</i>
TYPE OF TREATMENT	DATE(S)		PROVIDER/CLINIC NAME	DIAGNOSES/REASON
<input type="checkbox"/> OUTPATIENT MENTAL HEALTH TREATMENT				
<input type="checkbox"/> INPATIENT MENTAL HEALTH HOSPITALIZATION				
<input type="checkbox"/> OTHER (i.e., Residential, Partial Hospitalization, In-Home Services): _____				
COMMENT ON CHILD/ADOLESCENT'S MENTAL HEALTH TREATMENT HISTORY (describe further if needed):				
SUBSTANCE USE DISORDER & PROBLEM GAMBLING				
CURRENT/PAST SERVICES	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Had substance use disorder treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please complete table below.</i>
Had problem gambling treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TYPE OF TREATMENT	DATE(S)		PROVIDER/CLINIC NAME	DIAGNOSES/REASON
<input type="checkbox"/> OUTPATIENT SUBSTANCE USE DISORDER TREATMENT				
<input type="checkbox"/> INPATIENT TREATMENT FOR DRUGS/ALCOHOL				
<input type="checkbox"/> OTHER (i.e., Detox, Relapse Prevention): _____				
<input type="checkbox"/> PROBLEM GAMBLING TREATMENT				
COMMENT ON CHILD/ADOLESCENT'S SUBSTANCE USE DISORDER OR PROBLEM GAMBLING TREATMENT HISTORY (describe further if needed):				



CHILD & ADOLESCENT INTAKE

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Child's Medical History

MEDICAL ISSUES/CONCERNS & TREATMENT						
Primary Care Provider Name (i.e., pediatrician, nurse practitioner):						
Other Medical Providers Name(s):						
<i>If it has been more than one year since the child/adolescent's last physical exam, we recommend scheduling an appointment with their doctor or health care provider. We also recommend routine vision and dental appointments whenever possible. Please tell your clinician if you need assistance in this area.</i>						
How would you describe the child/adolescent's overall physical health? <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR						
Any allergies? (e.g., medicines, food, other) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW IF YES, WHAT ARE THEY ALLERGIC TO? _____ WHAT IS THE REACTION? _____						
CURRENT/PAST HEALTH PROBLEMS/LEARNING DISABILITIES	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN	IF YES, STILL OCCURRING?	IF YES, RECEIVING TREATMENT?
Developmental/cognitive delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<i>Please complete table below.</i>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did they lose consciousness? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	
Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Hygiene difficulties (e.g., stopped/infrequently bathes or changes clothes, has a body odor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Physically impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Seizures/convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Serious injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Speech or language impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Visually impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Other learning disability: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Other significant health problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
MEDICAL CONDITION	DATE(S)		PROVIDER/CLINIC NAME		TREATMENT/RESPONSES	
Have they ever had a surgery or procedure? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW IF YES, PLEASE EXPLAIN: _____						
MEDICATIONS						
CURRENT/PAST MEDICATIONS	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN		
Any currently prescribed and/or over-the-counter medications/supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please complete table on following page.</i>		
Are they taking the medications as prescribed (if applicable)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Have they ever been prescribed psychiatric medication (not listed in the following table)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	List medication names, doses, etc.:		



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MEDICATION NAME	DOSE	PRESCRIBER (IF APPLICABLE)	REASON	SIDE EFFECTS

COMMENT ON CHILD/ADOLESCENT'S MEDICAL HISTORY (describe further if needed):

Family Psychiatric/Medical History

Please fill out the family history to the best of your ability. Check all that apply to biological family. Please list any relatives on either side of the family who have had the following:

FAMILY ISSUES/CONCERNS	RELATIONSHIP TO CHILD/ADOLESCENT	MOTHER'S SIDE	FATHER'S SIDE
ADD/ADHD		<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse/drinking problems		<input type="checkbox"/>	<input type="checkbox"/>
Anxiety		<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum		<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder/Mania		<input type="checkbox"/>	<input type="checkbox"/>
Conduct/Antisocial		<input type="checkbox"/>	<input type="checkbox"/>
Depression		<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability		<input type="checkbox"/>	<input type="checkbox"/>
Learning problems		<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-compulsive disorder (OCD)		<input type="checkbox"/>	<input type="checkbox"/>
Personality disorder		<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric hospitalizations		<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia/other psychosis		<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse/drug problems		<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempts/killed themselves		<input type="checkbox"/>	<input type="checkbox"/>
Tics or movement disorders		<input type="checkbox"/>	<input type="checkbox"/>
Other medical problems: _____		<input type="checkbox"/>	<input type="checkbox"/>
Other behavioral/psychiatric problems: _____		<input type="checkbox"/>	<input type="checkbox"/>

COMMENT ON FAMILY PSYCHIATRIC/MEDICAL HISTORY (describe further if needed):



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Child's Developmental History

PREGNANCY				
How was the mother's overall health during the pregnancy with this child? <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> UNKNOWN				
MOTHER'S PROBLEMS/ILLNESSES DURING PREGNANCY	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Got injured/hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other problems/illnesses: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOTHER'S SUBSTANCE USE DURING PREGNANCY	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Drank alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe amount and frequency, participation in treatment, any birth defects or malformations due to drug/alcohol use:
Used tobacco/smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Took elicit/street drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Took medications (other than vitamins and iron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BIRTH/EARLY INFANCY				
ISSUES/COMPLICATIONS DURING BIRTH/EARLY INFANCY	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Baby born before they were due (premature)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Length of pregnancy: _____ weeks
Baby had issues/complications during/after delivery (i.e., Jaundice, infections, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
A NICU or extended hospital stay was required	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother experienced post-partum depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DEVELOPMENTAL MILESTONES				
DEVELOPMENTAL MILESTONES THEY DID LATE OR ARE STILL HAVING TROUBLE WITH	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Motor skills (e.g., sitting, rolling over, standing, walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/language (e.g., spoke first words, said phrases, sentences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-care (e.g., bladder trained, bowel trained, sleeping alone, dressing self)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social/Emotional (e.g., engaging peers, tolerating separation, playing cooperatively)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other developmental concerns: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
COMMENT ON CHILD/ADOLESCENT'S DEVELOPMENTAL HISTORY (describe further if needed):				



CHILD & ADOLESCENT INTAKE

CLIENT NAME/DOB/MRN
(or affix label)

Child's School Functioning & Education

CURRENT SCHOOL INFORMATION

Currently enrolled in school?

- YES, FULL-TIME (1st-12th grade: 20+ hours per week; kindergarten and >12 grade: 12+ hours per week)
- YES, PART-TIME (1st-12th grade: less than 20 hours per week; kindergarten and >12 grade: less than 12 hours per week)
- NOT IN EDUCATIONAL OR TRAINING ACTIVITIES
- DON'T KNOW

School name (if applicable):

Grade level OR indicate highest grade completed (if not currently enrolled in school):

- NEVER ATTENDED OR BELOW PRESCHOOL
- PRE-SCHOOL, HEAD START, NURSERY SCHOOL
- KINDERGARTEN
- GRADE: _____
- HIGH SCHOOL DIPLOMA OR GED
- SOME COLLEGE
- DON'T KNOW

School setting (if applicable, check all that apply):

- REGULAR PUBLIC SCHOOL
- REGULAR PRIVATE SCHOOL
- VOCATIONAL-TECHNICAL SCHOOL
- CYBER/ONLINE SCHOOL
- SPECIALIZED SCHOOL FOR YOUTH WITH EMOTIONAL/BEHAVIORAL PROBLEMS
- HOME SCHOOL
- OTHER SCHOOL SETTING: _____

ACADEMIC/SCHOOL FUNCTIONING

SCHOOL ISSUES/CONCERNS	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Grades/academic performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Held back a grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attendance/truancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Detentions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reason for disciplinary action (e.g., fights in school, talking back to teachers, threats of violence, etc.):
Suspensions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Expulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other disciplinary/behavioral concerns: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of detentions, suspensions, and/or expulsions?
Other academic issues/school concerns: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

LEARNING DISABILITIES/SPECIALIZED SERVICES	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Been tested for any learning disabilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Testing determined services were: <input type="checkbox"/> NOT NEEDED <input type="checkbox"/> NEEDED
Do they receive specialized services...				
Individualized Education Plan (IEP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please provide a copy of the IEP or 504 Plan if you haven't already done so.</i> Describe accommodations (Aide, Resource Room, special education, Gifted Program, etc.):
504 Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other specialized services: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

COMMENTS ON CHILD/ADOLESCENT'S EDUCATION/SCHOOL FUNCTIONING (describe further if needed):



CHILD & ADOLESCENT INTAKE

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(or affix label)

Child's Living Situation & Family Relationship

LIVING SITUATION

Current type of housing (check all that apply):

- APARTMENT GROUP HOME HOUSE OTHER: _____
 CONDOMINIUM HOMELESS MOBILE HOME _____
 CORRECTIONAL FACILITY HOTEL/MOTEL SHELTER _____

Does the child/adolescent live in more than one household? YES NO

IF YES, PLEASE EXPLAIN: _____

Was the child/adolescent adopted or guardianshiped? YES NO DON'T KNOW

IF YES, AT WHAT AGE? _____

HOUSEHOLD CONCERNS/STRESSORS	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Family member legal issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family member disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family member serious health problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family member incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financial concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lack of food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housing/utilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transportation needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Violence/safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other family stressors: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

COMMENT ON LIVING SITUATION (describe further if needed):

RELATIONSHIPS BETWEEN CHILD (CLIENT) AND PARENT/GUARDIAN

Please list below the names, ages, relationships, and other relevant information regarding the child/adolescent's parents/guardians/caregivers (i.e., biological parents, adoptive parents, step-parents, placement parents, etc.). Please indicate below the best descriptions of parent-child relationships.

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	OCCUPATION	AGE	LIVING WITH CHILD		QUALITY OF RELATIONSHIP			PARENT-CHILD CONFLICT		
				YES	NO	GOOD	FAIR	POOR	NONE/MILD	MODE-RATE	SEV-ERE
Biological Father				<input type="checkbox"/>							
Biological Mother				<input type="checkbox"/>							
				<input type="checkbox"/>							
				<input type="checkbox"/>							
				<input type="checkbox"/>							

Cooperation between parents regarding child-rearing? ALWAYS USUALLY INCONSISTENTLY RARELY N/A



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RELATIONSHIPS(S) BETWEEN CHILD (CLIENT) AND SIBLING(S)

Please list the names and ages regarding the child/adolescent's siblings (i.e., biological siblings, step-siblings, placement siblings, etc.).

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	LIVING WITH CHILD		QUALITY OF RELATIONSHIP			SIBLING-CHILD CONFLICT		
			YES	NO	GOOD	FAIR	POOR	NONE/MILD	MODE-RATE	SEV-ERE
			<input type="checkbox"/>							
			<input type="checkbox"/>							
			<input type="checkbox"/>							
			<input type="checkbox"/>							
			<input type="checkbox"/>							
			<input type="checkbox"/>							
			<input type="checkbox"/>							

RELATIONSHIP(S) BETWEEN CHILD (CLIENT) AND OTHER PEOPLE LIVING IN THE HOME

Please list below the names and ages regarding other individuals living in the same home as the child/adolescent (who weren't already listed in the tables above).

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	QUALITY OF RELATIONSHIP			INDIVIDUAL-CHILD CONFLICT		
			GOOD	FAIR	POOR	NONE/MILD	MODE-RATE	SEV-ERE
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENT ON FAMILY/HOME RELATIONSHIPS (describe family history and major life events such as moves, placement/foster care history, losses/death, etc.):



Child's Social Background

SOCIAL/PEER RELATIONSHIPS

Who does and/or can the child/adolescent count on for support (i.e., important friends, extended family members, neighbors, coaches, school staff, church/faith community, etc.)? _____

How are their relationships with peers at school? EXCELLENT GOOD FAIR POOR

How are their relationships with peers in the neighborhood/community? EXCELLENT GOOD FAIR POOR

Are they bullied by others?
 NEVER/RARELY (not a problem) SOMETIMES (can be a problem) OFTEN (definite problem) VERY OFTEN (major problem)
 IF YES, PLEASE EXPLAIN: _____

COMMUNITY, RECREATIONAL ACTIVITIES AND SUPPORTS

COMMUNITY RESOURCES/SERVICES UTILIZED	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
12-Step Program(s) (i.e., Alateen, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Boys & Girls Club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child Advocacy Center (CAC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family Haven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mentoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-help groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
School-based services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Youth Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other resources/services: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HOBBIES/ACTIVITIES INVOLVED IN	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
After-school activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Church/Religious service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Performing Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Volunteering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other hobbies/activities: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

What are the child/adolescent's strengths (personality traits, skills, etc.)? What strengths do they have that will help them reach their goals? _____

What does the child/adolescent do to cope with their problems/difficulties?

<input type="checkbox"/> EXERCISE	<input type="checkbox"/> PLAYS VIDEO/COMP. GAMES	<input type="checkbox"/> TIME ALONE	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> LISTEN/PLAY MUSIC	<input type="checkbox"/> READ	<input type="checkbox"/> WATCH TV/MOVIES	_____
<input type="checkbox"/> MAKE ART	<input type="checkbox"/> TALK TO FRIEND/FAMILY	<input type="checkbox"/> WRITING	_____
<input type="checkbox"/> PLAY WITH A PET	<input type="checkbox"/> TAKE BATH/SHOWER	<input type="checkbox"/> DON'T KNOW	_____

RELIGIOUS/SPIRITUAL AND CULTURAL INVOLVEMENT

	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Does the child/adolescent practice any particular cultural traditions, spirituality, and/or religion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Was religious faith part of the child/adolescent's upbringing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



CHILD & ADOLESCENT INTAKE

CLIENT NAME/DOB/MRN
(or affix label)

GENDER IDENTITY

	YES	NO	DON'T KNOW	COMMENTS/IF YES, PLEASE EXPLAIN
Has the child given any signs that they identify with a gender that is not consistent with their biological sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are they really uncomfortable with their assigned gender?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

SEXUAL DEVELOPMENT (FOR ADOLESCENTS AGED 12 TO 17 YEARS)

Have you ever had concerns about the adolescent's sexual development or behaviors? YES NO DON'T KNOW

IF YES, PLEASE EXPLAIN: _____

How does the adolescent identify their sexual orientation?

- STRAIGHT GAY LESBIAN OR GAY DON'T KNOW
 BISEXUAL LESBIAN DECLINE TO ANSWER OTHER: _____

Is the adolescent sexually active? YES NOT CURRENTLY NEVER DON'T KNOW

Which birth-control/protection does the adolescent use (if applicable)? _____

EMPLOYMENT

Child/adolescent's current employment status (check all that apply):

- FULL TIME DISABLED SELF-EMPLOYED: _____ DON'T KNOW
 PART TIME NOT EMPLOYED

Any employment history for the child/adolescent? YES NO DON'T KNOW

IF YES, PLEASE EXPLAIN: _____

LEGAL INVOLVEMENT

CURRENT/PAST LEGAL INVOLVEMENT	YES	NO	DON'T KNOW	IF YES, PLEASE EXPLAIN
Under department of corrections (JRA/DOC) supervision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is there a court order exempting the child/adolescent from reporting requirements? <input type="checkbox"/> NO <input type="checkbox"/> YES - <i>If so, a copy of the court order must be included in the record – please provide a copy.</i>
Under criminal court ordered mental health or substance use disorder treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legal charges (e.g., traffic, civil, DWI/DUI, criminal, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legal convictions (e.g., traffic, DWI/DUI, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Less restrictive alternative (LRA) or conditional release (CR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Served any time in detention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

COMMENT ON SOCIAL BACKGROUND (describe further if needed):

Additional Information

What else would you like for us to be aware of?