CHILD/ADOLESCENT INTAKE ASSESSMENT

Patient Name_____ Age:_____ D.O.B_____

Date:_____ Present at intake:_____

Referral Source:_____

PRESENTING PROBLEM (What are your concerns)

_____

_____

_____

_____

_____

_____

_____

PROBLEM/CONDITION INCLUDES: (Check all that apply)

Abuse/assault/rape victim
- ❑ Alcohol or Drug problems
- ❑ Failure to respond to prior Treatment
- ❑ Self-damaging behaviors
- ❑ Suicide threat/attempt/danger
- ❑ Depressed/Anxious Mood
- ❑ Educational Problems
- ❑ Medical Problems
- ❑ Family problems
- ❑ Social/Interpersonal problems
- ❑ Domestic violence
- ❑ Eating Disorder
- ❑ Sexual Identity Issues
- ❑ Occupational problems
- ❑ Legal Problems

_____

HISTORY OF BEHAVIORS:

- ❑ Fire Setting
- ❑ Enuresis
- ❑ Encopresis Problems
- ❑ Cruelty to animals
- ❑ Gambling
- ❑ Assaultiveness
- ❑ Use of Weapons
- ❑ Gang Involvement
- ❑ School Refusal
- ❑ Temper Tantrums
- ❑ Sexualized Behaviors
- ❑ Breathing/Choking Games
- ❑ Eating
- ❑ Sexual Abuse of others
- ❑ Suicide Attempts
- ❑ Theft
- ❑ Vandalism
- ❑ Verbal Agress.
- ❑ Runaway

MEDICAL CONDITION AND HISTORY:

Primary Physician: Clinic: Last Physical:

Current Illness or injuries? YES | NO _____

_____

Current Medications? | YES | NO (List names and dosage) _____

_____

_____

_____

Health History (include use of caffeine, smoking, eating habits): _____

_____

_____

_____

Has patient had any problems with physical pain? Y N

How severe? (1 2 3 4 5 6 7 8 9 10)

MENTAL HEALTH/AODA TREATMENT HISTORY

Prior outpatient treatment? |Yes | No Prior Inpatient Treatment? | Yes | No

TREATMENT FACILITY	DATES	REASON, OUTCOME

Psychotropic Medications? | Yes | No (Name, dosage, and dates).

_____

SUBSTANCE USE HISTORY AND PROBLEM BEHAVIORS

Have you been concerned about your AOD(alcohol and other drug) use? Y N

Have others been concerned about your AOD use? Y N

Has using AOD caused any problems for you? Y N

If AOD treatment prior AODA Treatment? Y N

Last use and amount of alcohol/drugs _____

Indicate and describe if any of the following are identified as problems: Gambling Pornography Computer/Internet

Unhealthy Sexual Activity Compulsive Eating _____

Other Significant History:_____

_____

_____

_____

FAMILY MEMBERS

Relationship	Name	Age	Residence	Notes

Nature of Current Relationship with Family Members: _____

_____

_____

_____

_____

Significant Childhood Stressors: (Check any that apply)

- ❑ Death of parent: Patient Age _____
- ❑ Death of Sibling: Patient Age _____
- ❑ Divorce: Patient Age _____
- ❑ _____
- ❑ Physical/Sexual abuse: Patient's age & Duration _____
- ❑ Domestic Physical Violence _____

_____

- ❑ Family Alcoholism/Drug Abuse or Dependency: One Parent Both Parents Other

_____

- ❑ Family Mental Health/Psychiatric Problems: _____

_____

- ❑ Other Childhood Stressors: _____

_____

PARENTING:

What strengths and deficits do the parents identify about themselves? _____

_____

_____

What are the patient's perceptions of the parent's strengths and deficits? _____

_____

What types of rules and consequences are employed by the caregiver? _____

_____

DEVELOPMENTAL HISTORY:

Pregnancy was: | Routine Problematic
Delivery was: | Routine Problematic:
Infant/child experienced significant illness or injury or surgery: | No | Yes

Explain: _____

_____

Mother's use of alcohol/tobacco/drugs/medications etc during pregnancy: _____

_____

Infant/Child was: "Easy" "Difficult" to care for or parent_____

_____

Comments and other significant information: _____

_____

ACADEMIC INFORMATION:

School attended _____ Grade:_____

School Performance_____

Attendance Problems: No Yes _____

History of Behavior Problems at School? No Yes _____

_____

_____

Special Education Instruction: No Yes _____

_____

Has there been a change in School Performance/Attendance? No Yes

School contact person_____

SOCIAL/PEER GROUP INFORMATION:

Social Activities/Interests: _____

_____

Support System:_____

_____

Hobbies/Interests:_____

Religious Involvement: _____

Work Experience: _____

LEGAL STATUS AND HISTORY:

Has Patient ever been arrested? No Yes

Has Patient ever been on probation? No Yes

Significant information and comments regarding legal status and history

_____

_____

_____

WHAT ELSE WOULD BE HELPFUL TO KNOW THAT WOULD ASSIST IN YOUR TREATMENT