

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)

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

HISTORY OF BEHAVIORS:

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

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

