Initial Intake Form - Youth

Therapist: _____ Today's Date: _____
Patient: _____ DOB: _____

Referral Information

Name of Emergency Contact: _____
Phone:_____
Who referred you to Quality Life Counseling:_____
Reason for referral? (brief description):_____
Name of Primary Care
Physician:_____Phone:_____
Address:_____Fax:_____
Guardian name/address/phone:_____
If DHHS involvement, DHHS worker name/address/phone:_____

General Behavioral Information

Description of current difficulties/"why now":
If any of the following are concerns for your child, please provide a brief description:

- ☐ Oppositional behavior:
- ☐ Anger/Aggressive behavior:
- ☐ Tantrums:
- ☐ Changes in mood/ interest in activities:
- ☐ Fears/unwanted thoughts:
- ☐ Unusual habits/repetitive behavior:
- ☐ Sleep problems/changes:
- ☐ Appetite problems/changes:
- ☐ Suicidal/homicidal thoughts:
- ☐ Self harming behaviors:
- ☐ Alcohol/drug use
- ☐ Sexual problems
- ☐ Victim of Abuse (sexual/physical)
- ☐ Neglect:
- ☐ Self-esteem:
- ☐ Adjustment (death/divorce/move):
- ☐ Toileting:
- ☐ Attention problems:
- ☐ Hyperactivity:
- ☐ Relationship problems:
- ☐ School problems:

Please describe what you are currently doing to work on these problems:_____

Which are most helpful? (example: go for a walk with a dog):_____

Patient Background Information/Family History

Patient Name: _____ Nickname: _____ **DOB**: _____
Home Address: _____ City: _____ State: ___ Zip: _____
Phone #: _____ May we contact you at this #? Yes_____ No_____
Email:_____
Sex (circle): Male / Female
Ethnicity (circle all that apply): African-American Asian-American Hispanic Native American Caucasian Other:_____
Problems with Ethnicity: Yes ____ No____
Religious/Spiritual Community does he/she belong?_____
Any practices/rituals that bring comfort? If yes, describe:_____

Biological parents are: married separated divorced never married
*If currently married, how long have you been married?_____

Patient resides with:_____
This person is (circle one): Biological parent Step-parent Grandparent Adoptive Foster Other:

Mother's name:_____ **Father's name:**_____
(circle one) Biological Step Adoptive Foster Other (circle one) Biological Step Adoptive Foster Other
Home Phone: _____ Home Phone:_____
Work Phone: _____ Work Phone: _____
Highest level of education: _____ Highest level of education: _____
Place of Employment: _____ Place of Employment: _____
Occupation: _____ Occupation: _____
Work Schedule:_____ Work Schedule:_____
Maternal mental health history: _____Paternal mental health history: _____
*If biological parent does not reside in the same home, please provide their name, address, and place of employment:_____
Visitation schedule with this person?_____
Other Members of the Household (in order from oldest to youngest) (e*xample: siblings, step-siblings, niece/nephew, foster children*):

Name	DOB	Sex	Relation to patient

Others residing in the home: (*for example, grandparents, non-custodial parent/step-parent, friend*)
Name(s) Relationship to patient Describe their relationship

_____

_____

Recent life stressors within last 12 months?
Family death_____ Abuse_____ Change in schools_____ Separation/divorce_____ Marriage_____
Addition to family_____ Family moved_____ Change in job_____ Health problems_____
Family financial problems_____ Any other major/important life event:_____

Academic & School Information

Child attends _____School
Child is currently in the _____ grade
School Teacher's Name(s):_____
Child's current grades are: _____
Grades last semester were:_____

Has child ever experienced the following in school…
Learning disability? Yes_____No _____ If yes, please describe:_____
Behavioral/emotional problems? Yes_____No _____ If yes, please describe:_____
Has your child ever been suspended, expelled, or retained in a grade? Yes____No _____
If yes, please describe:_____
Speech or language services? Yes_____No _____ If yes, please describe:_____
Has your child ever received any type of educational services/accommodations? Yes____No _____
If yes, please describe: *(example: Individual Education Plan)*_____

_____
Please describe type of student or quality of their work:_____
Please describe when the school problems (if any) started:_____
Please describe what the child's social involvement is at school (e.g., list some friends and/or extracurricular activities your child may be involved in):_____

Medical Information

Prenatal History:
Did you and/or your doctor note any problems with pregnancy? Yes_____ No_____ DK_____
Were there any illnesses, complications, or concerns during pregnancy with this child? What type?_____
How old were you when you became pregnant with this child? _____
Was the pregnancy planned?_____

Any substances or medications used during this pregnancy? Yes_____ No_____ DK_____
If yes, please describe:_____
Was there toxemia or eclampsia? Yes_____ No_____ DK_____
Was there an Rh factor incompatibility? Yes_____ No_____ DK_____
Signs of fetal distress during labor/birth? Yes_____ No_____ DK_____
Full Term (9 months)_____ Early_____ (days/weeks total____) Late_____ (days/weeks total____)
Delivery: Normal?_____ Breech?_____ Caesarian(C-section)?_____ Forceps?_____ Induced?_____
Child's birth weight? _____
Were there any complications during birth? Yes_____ No_____ DK_____ If yes, please describe:_____

Postnatal History:
Were there early infancy feeding problems? Yes_____ No_____ DK_____ If yes, please describe:_____
Was the child colicky? Yes_____ No_____ DK_____ If yes, please describe:_____
Were there problems with the infant's alertness? Yes_____ No_____ DK_____
If yes, please describe:_____
Did the child have any health/congenital problems? Yes_____ No_____ DK_____
If yes, please describe:_____

Developmental Milestones:
What is your general impression of your child's infant development? Good____ Fair____ Delayed____
What age did he/she sit up? (average 6 to 8 mos.) 3-6 mos____ 7-9 mos____ Over 9 mos____ DK____
What age did he/she crawl? (average 9 mos.) 6-12 mos____ 13-18 mos____ Over 18 mos____ DK____
What age did he/she walk? (average 12 to 18 mos.) Under 1 yr____ 1-2 yr____ 2-3 yr____ DK____
What age did he/she feed self? (average 10 to 12 mos.) 6-9 mos____ 10-12 mos____ 13-18 mos____ DK___
What age did he/she speak single words (other than mama/dada)? _____ DK_____
What age did he/she speak two or more words together (average 10 mos.)_____ DK_____
What age was he/she toilet trained (bladder control)? _____ DK_____
What age was he/she toilet trained (bowel control)? _____ DK_____

Medical/Physical Health History (please write anything this client has been treated for in the **PAST)**:
_____
_____

Please list any **CURRENT** health problems/concerns?:_____
Does your child have any physical health problems that may interfere with normal functioning (vision, hearing, gross motor skills, fine motor skills)? Yes_____ No_____
If yes, please describe: _____
Allergies/adverse drug reactions: Yes_____ No_____ If yes, please describe:_____
Last physical:_____ Which physician:_____
Describe exercise habits: _____
How much sleep does he/she typically get?_____

Any problems with sleep? None_____ Difficulty falling asleep?_____ Difficulty staying asleep?____
Restless sleeper?_____ Early riser?_____

Does he/she have problems with appetite? Yes_____ No_____ If yes, please explain:_____
Overeats_____ Average_____ Under eats_____ Picky eater (describe)_____

Suspicion of alcohol/drug use? Yes_____ No_____ If yes, please describe:_____
History of abuse/neglect? Yes_____ No_____ If yes, please describe:_____

Bladder control problems? Yes_____ No_____ If yes, please explain:_____
Bowel control problems? Yes_____ No_____ If yes, please explain:_____

Any PAST Medication(s)	Dose	Frequency	Purpose	Prescribed by
CURRENT Medication(s)	Dose	Frequency	Purpose	Prescribed by

Mental Health History

Previous Counselor(s)	Year(s)	Where	Response/reaction	Issue/Diagnosis
Previous Psychiatric hospitalization(s)	Year	Where	Response/reaction	Issue/Diagnosis

Substance abuse treatment(s)	Year	Where	Response/reaction	Issue/Diagnosis
Self help (SA, NA, AA, Al-Anon, etc)	Year	Where	Response/reaction	Issue/Diagnosis

Trauma History: Has client been the victim of any of the following? **List dates if possible**.

Sexual Abuse_____
Sexual Molestation_____
Emotional/Verbal Abuse_____
Physical Abuse_____
Neglect_____
Domestic Violence_____
Witness Domestic Violence_____
Violent Natural Disaster_____
Life Threatening Accident_____
Witness Life Threatening Accident_____
Financial Scam/Theft_____
Other events where life and safety are threatened

Risk Factors: Do you feel your child is at risk for suicide, homicide, elopement, substance abuse relapse, domestic violence, sexual assaulting, sexual molesting, etc? Please explain:

_____

Patient/Family Legal Concerns & Issues

Is he/she involved in any active cases (traffic, civil, criminal)? Yes_____ No_____
If yes, please explain specifics:_____
Is he/she presently on probation or parole? Yes_____ No_____
Has any member of the child's family been involved in legal concerns (victim/offender)? Yes No
If yes, please explain specifics:_____
Is there a history of drug or alcohol use within the family? Yes_____ No_____
If yes, please explain: _____
Other legal history? Yes_____ No_____

Charges (year of charge) Convictions Penalty Sentence Completed?

_____
_____

Substance	Y/N	Frequency	Duration	First Use	Last Use
Example	Y	1x a week	2 years	2012	2014
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

*Thank you for providing detailed information regarding your child. This will assist the therapist greatly in understanding your child's and your family's unique needs.

*The information provided on this form is for the purpose of mental/behavioral health evaluation and treatment only. The information provided on this form cannot be released without express written permission of the parent(s) or legal guardian of this child. If you have any questions about how this information will be used, please discuss your concerns with your therapist during your first visit.

I assert that the information provided on this document is true and accurate to the best of my knowledge.

_____

Client/Guardian Print and Signature ***Date***

_____

Witness Print and Signature ***Date***