Child/Youth Intake Form

08/17/10

CHILD'S INFORMATION:

NAME: ______________________________ **FCS ID#:** __________ **KAECSES #:** __________
First name Middle Initial Last Name

DOB:____________ **AGE:**_____ **SS NUMBER:**________________ **GENDER:** ☐ MALE ☐ FEMALE

ADDRESS: ______________________________ **APT.#:**__________

CITY:______________ **STATE:**_______ **ZIP:**__________ **COUNTY:**______________

PHONE NUMBER: ______________________ ______________________
Home Cell

RACE/ETHNICITY OF CHILD

☐ Caucasian/White ☐ Japanese ☐ Hispanic
☐ African American/Black ☐ Chinese ☐ Native American ☐ Biracial
☐ Asian ☐ Hawaiian ☐ Vietnamese ☐ Other

Are there any communication barriers for the child or parent/guardian? __________ **If so, please explain:** ______________

____

CAREGIVER INFORMATION:

☐ PARENT ☐ RELATIVE ☐ GUARDIAN ☐ RESOURCE PARENT

NAME:____
Last name First Name Middle Initial

ADDRESS: (if different)______________________________ **APT.#:**__________

CITY:______________ **STATE:**_______ **ZIP:**__________ **COUNTY:**______________

PHONE NUMBER: ______________________ ______________________ ______________________
Home Cell Work

Number of household members: ______________________________

Are there any immediate family members in the military?__________ **If so, have they served in combat?** __________

Who is legally authorized to receive information about and make decisions regarding this child's care?

____
Name and Relationship

CASE MANAGER/PO: ______________________ **AGENCY:** ______________ **PHONE:** ______________ ☐ N/A

WHO REFERRED YOU TO OUR AGENCY: ______________________________

____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT FOR THIS CHILD:______________

____

IS TREATMENT COURT ORDERED? YES ☐ NO ☐

EMPLOYMENT INFORMATION:

☐ Full-time Student ☐ Part-time Student ☐ Employed ☐ N/A

Name of Employer: ______________________ Job Title: ______________________

LEGAL HISTORY:

Has the child been charged with a crime ☐ Yes ☐ No Is the child on probation? ☐ Yes ☐ No

If yes, please explain**:** ____

Child's Name:______________________

SUBSTANCE USE HISTORY:

☐ NONE

☐ Alcohol ☐ Other substance use ____

Attended alcohol/drug abuse treatment: ☐Yes ☐No Has the child been told that they have an alcohol/drug problem: ☐Yes ☐No

GAMBLING HISTORY (PLEASE COMPLETE IF YOUR CHILD IS 12 YEARS OF AGE OR OLDER):

Are you seeking services for a gambling addiction: ☐ Yes ☐ No

If so, has the youth ever lied about their gambling: ☐ Yes ☐ No

If so, has the youth ever increased bets to get the same sense of action: ☐Yes ☐No

SCHOOL FUNCTIONING:

Current School:______________________________ ☐Elementary ☐Middle School ☐High School

Grade: _______ Teacher's Name:__________________________ School Phone Number:______________________

Past / Present truancy Yes ☐ No ☐

Expulsions Yes ☐ No ☐ Number __________ Dates ____________________________

Suspensions Yes ☐ No ☐ In school ☐ Out of school ☐ Number _____Dates __________________

Asked to leave a daycare/preschool Yes ☐ No ☐ Number _______ Dates ______________________

☐ 504 Plan ☐ Special Education / IEP ____

SOCIAL, PLAY AND RECREATION:

Describe the child's social, play and recreational interests:

____

____

PLACEMENT HISTORY:

☐ N/A

Type: Resource home, shelter, residential facility ___________________________ Kinship home

Dates/length of stay: ____

Reason for moving: ____

Type: Resource home, shelter, residential facility ___________________________ Kinship home

Dates/length of stay: ____

Reason for moving: ____

Please document additional placements on a separate page

CASE PLAN GOAL ☐ Reintegration ☐ Adoption ☐ Guardianship ☐ Maintenance at Home ☐ OPPLA ☐ NA

CONCURRENT CASE PLAN GOAL ☐ Adoption ☐ Guardianship ☐ OPPLA ☐ NA

MENTAL HEALTH HISTORY:

☐ No previous therapy

☐ Outpatient Treatment

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: ____________________________________

Dates of treatment: ____________________________

Reason for treatment: __________________________

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: ____________________________________

Dates of treatment: ____________________________

Reason for treatment: __________________________

Child's Name:______________________

INPATIENT PSYCHIATRIC HOSPITALIZATION:

Previously hospitalized: ☐ Yes ☐ No ☐ N/A   Multiple Hospitalizations: ☐ Yes _________

Last psychiatric facility ________________________________ Date Admitted __________Date Dismissed________

Please document additional hospitalizations on a separate sheet

PRIMARY CARE PHYSICIAN (PCP):

NAME:____ **PHONE:**___________________________

ADDRESS: ____

Visit/Checkup with PCP within the past 12 months: ☐ YES ☐ NO Regular preventative health screens: ☐ YES ☐ NO

CURRENTLY PRESCRIBED MEDICATIONS (Medication, dosage and prescribing physician):

____

____

Has the child been consistently taking these medications as prescribed ☐YES ☐NO

PATIENT MEDICAL/HEALTH: (Please check all that apply – past or current)

	PAST	CURRENT	N/A		PAST	CURRENT	N/A		PAST	CURRENT	N/A
ASTHMA	☐	☐	☐	HIGH BLOOD PRESSURE	☐	☐	☐	FREQUENT EAR INFECTIONS	☐	☐	☐
HEART DISEASE	☐	☐	☐	THYROID PROBLEMS	☐	☐	☐	DENTAL PROBLEMS	☐	☐	☐
CANCER	☐	☐	☐	LIVER DISEASE	☐	☐	☐	TUBERCULOSIS	☐	☐	☐
SEIZURES	☐	☐	☐	SIGNIFICANT WT. GAIN/LOSS	☐	☐	☐	GASTRO INTESTINAL PROBLEMS	☐	☐	☐
DIABETES	☐	☐	☐	HEPATITIS	☐	☐	☐	OTHER________________	☐	☐	☐
HEAD INJURY	☐	☐	☐	KIDNEY DISEASE	☐	☐	☐				

Are you currently being seen for any of the above? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_________________________

History of hospitalization due to a medical condition: ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_________________________

Medication Allergies ________________________________

NUTRITION: (Please check all that apply – past or current)

	PAST	CURRENT	N/A		PAST	CURRENT	N/A		PAST	CURRENT	N/A
INCREASED APPETITE	☐	☐	☐	BINGE EATING	☐	☐	☐	OTHER______________	☐	☐	☐
DECREASED APPETITE	☐	☐	☐	HOARDING	☐	☐	☐				

Are you currently being seen for any of the above? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_________________________

Food Allergies ____

I have made myself throw-up after eating ☐ YES ☐ NO I do not eat a wide variety of healthy foods ☐ YES ☐ NO

PAIN:

	PAST	CURRENT	N/A	
CHRONIC PAIN	☐	☐	☐	IF YES, PLEASE DESCRIBE: ____

Are you currently being seen for any of the above? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE_________________________

I experience a decrease in my ability to function in life due to this pain ☐ YES ☐ NO

PSYCHIATRIC HISTORY:

	PAST	OR CURRENT		PAST	OR CURRENT		PAST	OR CURRENT
ADHD	☐	☐	ABUSE: SEXUAL	☐	☐	OTHER ______________	☐	☐
ANXIETY	☐	☐	ABUSE: PHYSICAL	☐	☐			
DEPRESSION	☐	☐	EATING DISORDER	☐	☐			

Child's Name:______________________

DEVELOPMENTAL HISTORY:

PREGNANCY: ☐ FULL TERM ☐ PREMATURE ☐ LATE   DELIVERY: ☐ NORMAL DELIVERY ☐ C-SECTION

Problems during pregnancy____

MILESTONES:

WALKING __________ MONTHS *TALKING* ___________ MONTHS *TOILET TRAINED* ___________MONTHS

FAMILY MEDICAL HISTORY:
(Please mark each that apply with "1" for immediate family "2" for extended family)

___ Diabetes
___ Heart Disease
___ Anxiety
___ Psychiatric hospitalizations
___ Depression
___ Schizophrenia
___ Suicide attempts
___ Alcohol/drugs
___ ADHD
___ Bipolar Disorder
___ Antisocial behavior (difficulties – police/violence)

VISITATION ARRANGEMENTS:

Are there any custody/visitation arrangements? Please describe, noting any court orders:

____

____

FAMILY, CULTURE AND RELIGION: Describe the child's family, cultural and religious connections.

____

____

BEREAVEMENT AND GRIEF: Has the child experienced grief and or loss? If so, describe how your family is supported socially, spiritually and culturally.____

____

GENERAL FUNCTIONING:
(Please check all that apply)

☐ Cheerful/happy mood most of the time
☐ Sad or tearful most of the time
☐ Feelings of hopelessness
☐ Withdrawn behaviors
☐ Difficulty thinking
☐ Under active/sluggish behavior
☐ Intentional self harm
☐ Suicidal thoughts
☐ Suicide attempts
☐ Increased appetite
☐ Decreased appetite
☐ Nightmares
☐ Takes more than an hour to fall asleep
☐ Night waking for longer than 30 minutes
☐ Hard to wake up in the morning
☐ Unable to sleep in own bed through the night
☐ Sleepwalking
☐ Extreme ups and downs in mood
☐ Irritability/anger
☐ Distinct periods of nonstop activity
☐ Exaggerated view of abilities
☐ Fast/rapid speech
☐ Feels rested after 3-4 hours sleep/ night
☐ Fearless/engaging in reckless activities
☐ Fearful of places, situations or people
☐ Worries about ____________________
☐ Wetting accidents
☐ Soiling Accidents
☐ Sexual inappropriate touching of others
☐ Sexual play with toys or objects
☐ Excessive masturbation
☐ Intentional vomiting/purging
☐ Difficulty concentrating
☐ Conflict with authority figures
☐ Stealing
☐ Physical cruelty to animals
☐ Physical aggression
☐ Verbal threats to harm others
☐ Threat to kill with intent /plan
☐ Lying
☐ Extreme conflict with siblings
☐ Running away
☐ Poor social skills
☐ Inability to complete tasks
☐ Inability to sustain attention
☐ Inability to remain seated
☐ Overactive/hyperactive behavior
☐ Easily distracted
☐ Poor self-care/poor hygiene

WHEN DID THESE CONCERNS BEGIN?

____

____

____

Child's Name:_______________________

HOW OFTEN DO THESE OCCUR?

____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD?

____

____

CONSENT AND AUTHORIZATION

By signing below you are:

- Authorizing Youthville to provide the client with mental health services.
- Acknowledging that Youthville will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- Acknowledging that you have been informed that services not covered by the insurance company will be the responsibility of the client (or parent or guardian if the client is under 18 years of age).
- Acknowledging that you have received a copy of the Client Rights and Responsibilities.

CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)

Signature X____ Date________________
Must Be Signed by Client or by Parent or Guardian if Client is Under 18 Years of Age.

Youthville is an equal opportunity employer. Services are provided to people without regard to race, religion, color, sex, ancestry, national origin, handicap, age or political affiliation.