

Youth Clinical Intake

Parent or Legal Guardian is asked to complete this form for any youth under the age of 18 as this will expedite the counseling process. This information will remain confidential.

Date: _____ **Responsible Party:** _____

DOB: ____ / ____ / ____ **SSN#:** _____ **Insurance:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Employed at: _____ **Work Address:** _____

Gross Yearly Income of Household: <\$25,000 < \$50,000 < \$75,000 > \$75,000

Emergency Contact Name: _____ **Phone #:** _____

How did you hear about us? _____ **Referred by:** _____

Are you Currently Involved in Church? Yes No If yes, indicate where you attend church and how frequently:

Youth's Name: _____ **DOB:** ____ / ____ / ____ **SSN:** _____

Ethnic Origin: _____ **Gender:** Male Female

Youth's Family Member Information:

	Name	Age and DOB	Describe Youth's Relationship With Them
Father:			
Mother:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Significant Other:			

Youth's Educational Background:

Current School: _____ **Teacher:** _____ **Grade Level:** _____

Average Grades: _____ **Any Behavior Concerns:** Yes No If yes, describe _____

How does the youth get along with peers? _____

Does the youth have an Individual Education Plan? Yes No If yes, what is it for? _____

Legal History:

Has the youth ever been arrested? Yes No If yes, indicate arrested for what and when: _____

Developmental History: Does the youth have any developmental delays? Yes No If yes, describe _____

Trauma History: Has the youth experienced past trauma? Yes No If yes, describe _____

Medical History: Does the youth have any medical issues? Yes No If yes, describe _____

Date of last medical exam: _____ **Medical Doctor & Phone #:** _____



Psychiatric History: Has the youth attended counseling previously? Yes No

When (specify dates):	Where and with Whom:	Presenting Issues at that Time:	Diagnosis Given:

Psychotropic Medications: Is the youth currently taking any psychotropic medications? Yes No (specify current & past meds)

Medication	Condition	Dosage	Dates of Usage	Side Effects	Physician

Alcohol/Drug Usage: Does the youth currently use alcohol or drugs? Yes No Used drugs/alcohol in the past? Yes No

Describe the use of drugs and alcohol (type, amount, frequency): _____

When did the youth start using drugs or alcohol? _____

What has the youth's past usage of drugs or alcohol been like? _____

Suicide Risk: Has the youth ever thought about or tried to hurt himself? Yes No

If yes, when? _____ How many times? _____

How or what did the youth plan to do? _____

What were the circumstances at the time? _____

Has anyone close to the child/youth ever committed suicide? Yes No If yes, who, how, and when: _____

Abuse History: Has the youth ever been physically, emotionally, or sexually abused? Yes No

If yes, briefly explain (who, what, and when): _____

Check the following symptoms/behaviors that the child/youth has experienced in the last thirty days:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Lack of Motivation |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Change in Eating Behavior | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Physical Complaints | <input type="checkbox"/> Easily Annoyed or Irritated | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Uncontrolled Temper Outbursts | <input type="checkbox"/> Guilt, Remorse, Shame | <input type="checkbox"/> Cruelty Towards Animals |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Uncontrolled/Unprovoked Crying | <input type="checkbox"/> Lack of Concentration |
| <input type="checkbox"/> Subjective Feelings of Depression | <input type="checkbox"/> Generalized Anxiety | <input type="checkbox"/> Difficulty with Decisions |
| <input type="checkbox"/> Specific Anxiety | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Aggression Towards Others |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fear | <input type="checkbox"/> Self-Harming Behavior |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Negativistic | |

Support Systems: Does the youth have people that he/she can turn to for support? Yes No If yes, who? _____

Strengths: What do you feel are the youth's strengths? _____

Presenting Issues: Briefly explain why the youth is seeking counseling at this time: _____

Goals: What do you hope to achieve through counseling? _____

