



CHILD & ADOLESCENT INTAKE ASSESSMENT¹

This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.

Clinician Use Only: ID: _____ Date: _____
Time In/Out: _____ Units: _____
Intake Assessment, Code ADMN (New) or ADMR (Reopen)

IDENTIFYING INFORMATION

Client Name: _____ DOB: _____ Age: _____
 Male Female Height: _____ Weight: _____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

School Status: _____ Cultural Identity: _____

Living with Whom? _____ How long in area? _____

Type of Residence: _____ Who referred you? self friend
 family member law enforcement
 mental health professional physician/nurse
 ad in phone book minister
 agency co-worker
 Other _____

PARENT INFORMATION

Your Name: _____ Age: _____

Other parent in residence Name: _____ Age: _____

How long have you been the primary caretaker? _____

Do you share joint custody? yes no If yes, how long? _____

If divorced, does the other custodial parent agree services should be sought? yes no don't know

Will both parents in residence be involved in treatment? yes no don't know

Will both biological parents be involved in treatment? yes no don't know

¹Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

If divorced, other Biological Parent's Name: _____ Age: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Message Phone: _____

If there is joint custody, list any recent problems _____

PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason for seeking help today? _____

How would you rate the severity of this problem? moderate significant extreme

How long this been a problem? _____

How often does the problem occur? constantly daily weekly monthly less often

Has there been:

Suicide thinking or attempts In the last month? Today _____

Thoughts of harming others or attempts In the last month? Today _____

How difficult was it to get your child or adolescent to come for help? _____

In what ways have the problems troubled you? _____

Is there a court order to receive treatment? yes no

On the next page are some common problem areas for children/adolescents. To help focus on the most important issues, please complete the following checklist.

What do you hope to get from treatment? _____

What do you expect from your treatment team? _____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in treatment? _____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

CHILD/ADOLESCENT STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **two (2)** resources (**strengths**) of your child or adolescent that will help in treatment?

- | | | |
|---|---|---|
| <input type="checkbox"/> Family Support | <input type="checkbox"/> Network of Friends | <input type="checkbox"/> Spiritual |
| <input type="checkbox"/> School | <input type="checkbox"/> Stable Finances | <input type="checkbox"/> Available Transportation |
| <input type="checkbox"/> Intelligence | <input type="checkbox"/> Good Health | <input type="checkbox"/> Other: _____ |

Your child or adolescent possesses many different **abilities** that can be utilized to help overcome problems. What are **four (4)** of abilities that may be most useful in treatment? He or she can ...

- | | | |
|---|--|--|
| <input type="checkbox"/> take medication | <input type="checkbox"/> be assertive | <input type="checkbox"/> express thoughts and feelings |
| <input type="checkbox"/> work cooperatively with others | <input type="checkbox"/> provide leadership | <input type="checkbox"/> abstain from alcohol/drugs |
| <input type="checkbox"/> request help from others | <input type="checkbox"/> resolve conflicts | <input type="checkbox"/> analyze problems |
| <input type="checkbox"/> use self-help materials | <input type="checkbox"/> keep appointments | <input type="checkbox"/> develop solutions to problems |
| <input type="checkbox"/> follow directions | <input type="checkbox"/> complete tasks assigned | <input type="checkbox"/> manage time effectively |
| <input type="checkbox"/> maintain consistent behavior | <input type="checkbox"/> other: _____ | <input type="checkbox"/> other: _____ |

FAMILY AND SIGNIFICANT RELATIONSHIPS

Child / Adolescent raised by? parents grandparent(s) single parent Other _____

What do you think about how your child was raised? _____

What kind of relationship do you have today with your child? _____

How many brothers or sisters does your child have? _____

What kind of relationship does your child have with his or her brothers and sisters? _____

Parent Marital Status?

never married married divorced separated widow(er) living as married

How many times have you been married? _____ How long each time? _____

Total number of children: ___ his ___ hers ___ ours. If children live with you, please give:

Name: _____ Age ___ Sex ___ his hers ours

Name: _____ Age ___ Sex ___ his hers ours

Name: _____ Age ___ Sex ___ his hers ours

Name: _____ Age ___ Sex ___ his hers ours

What problems exist in your current intimate relationship? _____

How much stress do you feel from parenting? None Some A lot Overwhelmed

How many close friends do you have? _____ How well do you get along with others? _____

To what organizations, clubs or teams do you belong? _____

What problem(s) have you, your spouse and other children had? What about extended family?

Problems with	Father	Father's Mother	Father's Father	Father's Brother(s)	Father's Sister(s)	Father's Uncle(s)	Father's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Problems with	Mother	Mother's Mother	Mother's Father	Mother's Brother(s)	Mother's Sister(s)	Mother's Uncle(s)	Mother's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Child's or Adolescent's Brothers and Sisters -- WRITE IN *FIRST NAME(S)* IF A PROBLEM

Problems with	Brother(s) First Name(s)	Sister(s) First Name(s)
Aggressiveness, defiance behavior as a child		
Attention, overly active, and/or poor impulse control as a child		
Learning disability		
Dropped out of school		
Mental Retardation		
Psychosis or schizophrenia		
Depression lasting more than two (2) weeks		
Anxiety disorder than impaired school work		
Tics or Trourette's Disorders		
Alcohol and/or Drug Abuse		
Law Enforcement		
Physical Abuse		
Sexual Abuse		

DAILY ACTIVITY STRENGTHS AND LIMITATIONS

CHILD / ADOLESCENT DAILY ACTIVITIES¹		Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank
1. Personal Care	Helps or manages general cleanliness: daily bath, shower, brush teeth	
2. Grooming	Assists or manages general appearance: hair, shave, comply with school rule	
3. Dress	Assists or responsibly cares for clean clothes, comply with school dress code	
4. Household Stability	Contributes to stability in the home (age-wise): respects others & property, shares in chores, involves caretakers in school-related projects, grades	
5. Physical & Mental Health	Assists or manages adequate weight, moods, outdoor exercise, aches; takes medications or over-the-counter drugs only with adult supervision.	
6. Communicate	Greets adults; listens, expresses feelings, anger, opinions effectively.	
7. Safety within environment	Plays it safe? Avoids guns, knives, matches, dangerous people or places where there likely is trouble or abuse; if driving, has safe record.	
8. Managing Time	Assists or manages time for promptly, regularly attending school & work (age-appropriate); completes tasks, sleeps, wakes up, eats on regular basis?	
9. Managing Money	Reliably handles or manages monetary allowance: abstains from overspending personal limits, betting, stealing, and borrowing?	
10. Nutrition	Eats at least 2 basically nutritious meals with caretakers; eats healthy snacks.	
11. Problem Solving	Understands presenting problems, reasons for seeking services; focuses on possible solutions for age-appropriate time periods; assists or manages difficult situations	
12. Family Relationships	Feels close to at least one other person at home; gets along with family or caretakers, feels loved?	
13. Alcohol, Drug Use	Abstains from smoking cigarettes, drinking alcohol, doing drugs or inhalants of any kind; avoids high risk drinking situations & people who use drugs	
14. Leisure Entertainment	Enjoys 2 or more fun & relaxing activities: music, watching or playing sports, reading, computer-board games, cards, artistic hobbies, movies, TV?	
15. Community Resources	Uses community activities, resources: after-school sponsored tutoring, clubs, sports, Scouts, YM/YWCA, library, church, dance.	
16. Peers/Social	Makes, keeps same-age friends; avoids bullying, gangs, cults, antisocial groups	
17. Sexual Behavior	Behavior is sexually responsible with girls, boys (and age-appropriate)? Avoids sexual activities, infections, pregnancy?	
18. Work & Productivity	Feels good about performance at school, considers grades to be good, completes school projects without undue difficulty. Has vocational goals.	
19. Coping Skills	Accepts adult correction without undue arguing, temper outburst; tolerate frustration, copes with disappointments, retains self-worth.	
20. Behavior Norms	Controls threatening or physical expression of anger, violent behaviors--either to self or others or to property. Law-abiding and responsible with rules, car, etc.	

²Adapted from Daily Living Activities Scale, Willa Pressmanes, used with permission.

DISCIPLINE

What methods have been used to discipline the child or adolescent?	Successful	Unsuccessful
Verbal reprimands		
Time out (isolation)		
Removal of privileges		
Removal of toys or activities		
Rewards		
Physical punishment		
Spend time with		
Let them have their way		
Avoid conflict		

How often does your child or adolescent comply with your first command? Always Never
 More than half the time Less than half the time

How often does your child or adolescent eventually comply with your commands? Always Never
 More than half the time Less than half the time

How much agreement and consistency do you and your spouse show in discipline? Always Never
 More than half the time Less than half the time

SPIRITUAL BACKGROUND

Are you a member of a local religious group? yes no Which one? _____

How active are you? extremely very somewhat not at all

How important is your faith? extremely very somewhat not at all

How might your faith/spirituality help? _____

Is there any spiritually related information you would like to add?

DEVELOPMENTAL FACTORS

Mother's health during pregnancy? Good Fair Poor Don't know

Alcohol consumed during pregnancy? yes no If yes, how much? _____

Street Drugs consumed? yes no If yes, used _____

During pregnancy used Tranquillizers (Valium, Librium, Xanax)? Cigarettes? Diabetes medication?

Coffee or caffeine drinks? Seizure Medication? Antibiotics? Sleeping Medication?

Psychiatric Medication _____

Number of previous pregnancies? _____ This delivery was Normal? Early? Long Labor?
 Eclampsia? Problem of Toxemia? Rh Incompatibility? Unusual Stress? Breech delivery?
 Water broke more than 24 hours early? Induced delivery? Forceps? Cesarean?
 Birth Defects? _____

As an infant, child was Normal? Slow? Advanced? Other _____

As a toddler, child was Normal? Slow? Advanced? Other _____

Bladder training problems? If so, started at age _____ He or she _____

Bowel training problems? If so, started at age _____ He or she _____

Ear problems? If so, started at age _____ He or she _____

Sleep problems? If so, started at age _____ He or she _____

Eating problems? If so, started at age _____ He or she _____

Other pre-school problems? _____

MEDICAL HISTORY

How is your child's or adolescent's health? Very Good Good Fair Poor Very Poor

He or she has been treated for Hearing Vision Coordination Speech Breathing

Chronic health problem(s): _____

Has your child or adolescent had any of the following illnesses?

Mumps	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>
Measles	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Lead Poisoning	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Frequent runny nose	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	Frequent sinus infection	<input type="checkbox"/>

Other: _____

Has your child or adolescent had any of the following accidents?

Broken bones	<input type="checkbox"/>	Severe lacerations	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	Severe bruises	<input type="checkbox"/>
Stomach pumped	<input type="checkbox"/>	Eye injury	<input type="checkbox"/>
Lost teeth	<input type="checkbox"/>	Sutures	<input type="checkbox"/>

Other: _____

Has your child or adolescent had any of the following?

Tonsillitis	<input type="checkbox"/>	Adenoids	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>
Eye, ear, nose, & throat	<input type="checkbox"/>	Digestive Disorder	<input type="checkbox"/>
Urinary tract	<input type="checkbox"/>	Foot, Leg or Arm Disorder	<input type="checkbox"/>
Burns	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>

Other: _____

Has your child or adolescent had any of the following symptoms in the past 60 days?

Ankle Swelling	Coughing	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Penile Discharge	Urination Difficulty
Breathing Difficulty	Pulse Irregularity	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Cramps	<input type="checkbox"/> Bedwetting
Vomiting	<input type="checkbox"/> Vision Changes	Seizures	Vaginal Discharge	Blood in Stool
<input type="checkbox"/> Muscle Weakness	Shakiness	Dizziness	Nervousness	<input type="checkbox"/> Diarrhea
Mole/Wart Changes	Tremor	<input type="checkbox"/> Falling	Sleep Problems	<input type="checkbox"/> Constipation
Hair Change	Nosebleeds	Confusion	Gait Unsteadiness	<input type="checkbox"/> Sweats (Night)
Hearing Loss	Chest Pain	Panic Attacks	Numbness	<input type="checkbox"/> Sweats (Other)
<input type="checkbox"/> Headaches	<input type="checkbox"/> Tingling in Arms & Legs	Loss of Consciousness	Rash	<input type="checkbox"/> Bleeding gums

SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Did your family or school provide sex education? yes no

Is there a problem with sexual behavior? yes no

Was child ever forced to have sexual contact? yes no When? _____

Has he or she contracted a sexually transmitted disease? yes no

Sexually active in any way? yes no

What other significant sexually oriented problems do you wish to discuss?

LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Has your child or adolescent had contact with law enforcement? yes no

Has you child or adolescent ever been arrested or taken to court? yes no

Has your child or adolescent ever been placed in a correctional institution? yes no

If yes, when? _____ How Long? _____ Where? _____

Current legal issues or problems? _____

MENTAL HEALTH HISTORY & TREATMENT

Check here if child or adolescent has never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From:	Date to Date	For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From:	Date to Date	For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

***Thank you for taking the time to complete this background information.
Please place this in the envelope provided, put your name on the outside and seal to insure privacy.
Bring to your appointment.***