MINOR INTAKE FORM

General Information

Assessment Date:

Revision Date

Child's Full Name: _____ Child's DOB: _____

Parent(s)/Caregiver(s) Names: _____

_____

Insurance Provider/Policy Number: _____

_____

Address: _____

Home: Cell: Work:

Email:

What issues do the family/caregiver and the child identify as problematic and in need of treatment?

_____

_____

_____

_____

What strengths and abilities (skills and talents) can each bring to bear on those issues?

_____

_____

_____

_____

FAMILY INFORMATION & BEHAVIORAL CONCERNS

Has the child been a danger to others? If yes, specify.

Has the child been a danger to self? If yes, specify.

Has the child experienced any of the following stressful events within the past 12 months: *(select all that apply)*

_____ Family divorce/separation

_____ Family accident or illness

_____ Death in the family

_____ Death in a close relationship

_____ Parent or caregiver job change

_____ Child changes schools

_____ Family move

_____ Family financial problems

_____ Other significant event

Has the child ever feared that she/he will be injured or killed?

Unknown _____ No _____ Yes _____ When? _____

_____

Has the child ever feared that a family member or anyone else will be injured or killed?

Unknown _____ No _____ Yes _____ Who/when? _____

_____

_____

_____

_____

Based on age group, check all symptoms that apply:

0-18 mos:

_____ Excessive crying

_____ Arching/stiffening when held or touched

_____ Cannot be consoled by caregiver

_____ Requires extensive assistance to initiate/maintain sleep

_____ Other (specify)

_____ None of these

Comment:

_____

_____

_____

18-36 mos: any of the above, plus

_____ Extremely destructive, dangerous, violent behavior

_____ Excessive frequent tantrums

_____ Persistent, intentional aggression

_____ Excessive, persistent self-injurious behavior

_____ Excessive, persistent self-stimulating behavior

_____ Absence of fear or awareness of danger

_____ Challenging behaviors/does not follow directions

_____ Other (specify)

_____ None of these

Comment:

_____

_____

_____

3-5 yrs: any of the above, plus

_____ Unintelligible speech

_____ Excessively withdrawn

_____ Doesn't play, interact with peers

_____ Unusual eating patterns or non-food items

_____ Clear loss of previously attained skills

_____ Other (specify)

_____ None of these

Comment:

_____

_____

_____

Has the child experienced or been exposed to extreme, violent behavior in the last 90 days?

_____

_____

_____

_____

Does the child manifest persistent difficulties or disruptive behaviors sufficient to jeopardize home or school placement?

Has the child exhibited bizarre or unusual behavior in the last 90 days?

FAMILY AND HOME ENVIRONMENT

What is the child's current living situation: physical arrangements, others living in the home?

Are there any social/recreational activities or hobbies the family does together?

Do you have any personal, religious, spiritual or cultural practices or beliefs that you want taken into account when working with you and your child?

Is there anything else you'd like us to know?

CHILD'S DEVELOPMENTAL HISTORY

How was the mother's overall health during pregnancy/birth?

_____

_____

In the three months before pregnancy, did the mother use any alcohol, tobacco, drugs, or prescribed medications? ____ No ____ Yes ____ Unknown

If yes, what specifically was used?

_____

_____

During the pregnancy, did the mother continue to use alcohol, tobacco, drugs, or prescribed medications? ____ No ____ Yes ____ Unknown

If yes, what specifically was used?

_____

_____

Did the mother: (select all that apply)

_____ Have a routine pregnancy?

_____ Have a complicated pregnancy?

_____ Have any medical or emotional problems during the pregnancy?

_____ Have an Rh factor incompatibility?

_____ Received medications to ease labor pain?

_____ Indicate the medication used:

_____ Unknown

Mother's age at time of child's birth?

_____

_____

Any health complications for mother following the birth? ___ No ___ Yes
If yes, describe:

_____

_____

Following birth, did the child have any immediate health problems? __No __Yes

If yes, describe: _____

_____

MEDICAL HISTORY

Does the child have: (select all that apply)

_____ Asthma? _____ Allergies?

_____ Diabetes? _____ Heart problems?

_____ Obesity? _____ Seizures?

Other chronic health problems? If yes, describe: _____

_____

_____

When was the child's last physical examination?

_____

_____

Any problems during infancy regarding: (select all that apply)

_____ Feeding ____ Colic____Excessive crying

_____ Sleep pattern difficulties _____ Infant responsiveness

_____ Activity levels

Other health concerns? If yes, describe:

_____

_____

Are the child's immunizations current? ___ Unknown ___ No ___ Yes

Does the child see a doctor regularly? ___ Unknown ___ No ___ Yes
If yes, describe:

_____

_____

Has the child ever been hospitalized for a medical condition?

___ Unknown ___ No ___ Yes

If yes, how often, for what condition(s), duration, and outcome(s)?
List any previous surgeries:

_____

_____

Has the child had a history of accidents or repeated accidents?

___ Unknown ___ No ___ Yes

If yes, describe:

_____

_____

Has the child ever had an accident or injury resulting in: (select all that apply)

____ Head trauma ____ Headaches

____ Blurred vision ____ Loss of consciousness

____ Not applicable ____ Unknown

Does the child experience any sleeping problems: (select all that apply)

___ Falling asleep ___ Staying asleep

___ Early awakening ___ Loss of consciousness

___ Nightmares ___ Night terrors

___ Sleep walking ___ Not applicable

Does the child experience: (select all that apply)

___ Appetite control problems ___ Bladder incontinence

___ Bowel incontinence ___ Not applicable

Any other medical or physical issues regarding the child that should be noted?

___ No ___Yes

If yes, describe:

_____

_____

_____

Any medical or physical issues regarding the child's family/caregivers that should be noted?

_____ No _____Yes

If yes, describe: _____

Does the child have a current/past history of substance abuse?

_____ No _____ Yes _____ Unknown

If yes, Please list substance below:

_____

_____

Have there been any legal/other consequences of the child's substance abuse?

_____ No _____ Yes _____ Unknown

If yes, describe:

_____

_____

Does the child's family/caregivers have a current/past history of alcohol or substance abuse?

_____ No _____Yes

Identify family member role(s) and details including treatment outcomes.

Have there been any legal/other consequences of family/caregiver substance abuse?

_____ No _____Yes ____Unknown

If yes, describe:

How would you rate the child regarding his/her:

	Excellent	Good	Fair	Poor
Hearing				
Vision				
Gross motor coordination				
Fine motor coordination				
Speech articulation				
Emotional regulation				
Sensory Integration				

*Please describe any difficulties:

Has the child had any alcohol or substance abuse treatment, to include: (select all that apply)

_____ Medication management? Outcome? _____

_____

_____

_____ Alcoholics/narcotics anonymous? Outcome?_____

_____

_____

_____ Outpatient care? Outcome?_____

_____

_____

_____ Inpatient care? Outcome?_____

_____

_____

_____ Not applicable_____

_____

_____

Has the child reached puberty? _____No _____ Yes _____ Unknown

What is the child's sexual orientation?

Unknown

Is the child sexually active? _____No _____ Yes _____ Unknown

Has the child received sex education? _____ No _____ Yes

Has the child ever engaged in any inappropriate sexual behavior?

_____ Unknown _____ No _____ Yes

If yes, describe:

_____

_____

_____

Describe any history of sexual victimization:

_____

_____

_____

Legal History

Has the child ever: (select all that apply)

_____ Been detained or arrested by any law enforcement agency?

_____ Gone to court or appeared before Juvenile Master for legal infractions?

_____ Been on parole/probation or under court supervision?

_____ Been remanded to Detention Center or County/State Training Schools?

_____ Not applicable

MENTAL HEALTH HISTORY

Has the child ever received a mental health diagnosis?___ No ___Yes

If yes, please describe the diagnosis:

_____

_____

_____

Has the child had any history of emotional or physical abuse? ___ No ___Yes

Has the child ever been exposed to violence? ___No ___ Yes

CHILD'S EDUCATIONAL INFORMATION

Child's current grade level:

_____

_____

How is the child doing academically:

_____

_____

Describe the child's behaviors in school and abilities/difficulties in getting along with teachers, and classmates:

_____

_____

A current IEP/504? ___ No ___ Yes

Does any known relative have or had a mental health condition? Indicate the mental health condition and relationship to the child.

Has the child ever been prescribed medication(s) for psychological, emotional or behavioral problems? ___ No ___Yes

Medication	Dosage/Frequency	Start Date	D/C Date

I Hereby certify that all the information provided is current and accurate:

Signature Date