Families Matter
Adolescent Intake Assessment

Today's Date:_____

IDENTIFYING INFORMATION
Name:_____ Sex: ___ Age:____ D.O.B.: _____

Parent/Guardian's Name:_____ Relation to Child:_____

Address:_____

Phone #:_____

CURRENT SITUATION

What concern brings you here: (How long has this been a problem?)
(What have you done, or are you doing, to resolve this problem?)

_____

_____

_____

_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)
None = this symptom is not present at this time · **Mild** = Impacts quality of life, but no significant impairment of day to day functioning · **Moderate** = Significant impact on quality of life and/or day to day functioning · **Severe** = Profound impact on quality of life and/or day to day functioning

	None	Mild	Moderate	Severe
Depressed mood				
Fatigue/low energy				
Poor concentration				
Poor grooming				
Mood swings				
Irritability				
Anxiety				
Obsessions/phobias				
Bingeing/purging				
Panic attacks				

Anorexia				
Laxative/diuretic abuse				
Hallucinations				
Aggressive				
Sexual dysfunction				
Grief				
Hopelessness				
Social isolation				
Guilt				
Hyperactivity				
Self-mutilation				
Paranoid				
Substance abuse				
Suicidal ideation				
Other (specify)				

FAMILY HISTORY

Did the mother use any of the following during pregnancy?

□ Alcohol □ Marijuana/crack/cocaine □ Prescription drugs
□ Cigarettes □ Coffee/ caffeine drinks □ none of the above

Parents current marital status: □ married □ mother remarried
□ separated □ father remarried
□ divorced □ mother cohabitating
□ partner deceased □ father cohabitating

Custody Status: ___ Birth Parents ___ Joint Custody
___ Mother Only ___ Adopted: Age of Adoption __
___ Father Only ___ Ward of the Court
___ Other relative – please specify _____

Frequency of contact between the non-custodial parent and your child/adolescent:
_____
_____

List all the people who are currently living in the household:

Name	Age	Relationship to Adolescent

List sibling(s) not living in the household:

Name	Age	Relationship to Adolescent

Is your child experiencing any problems in relationships with: (check all that apply)\

□ Mother	□ Stepmother	□ Child Care Providers
□ Father	□ Stepfather	□ Other
□ Siblings	□ Step-siblings	□ None of the Above

Comments:

Have any family members had problems with substance abuse (drugs, alcohol) or with mental/emotional problems? □ yes □ no

Comments:

BEHAVIORAL/HEALTH HISTORY

□ Drug/alcohol use	□ indecisive	□ Physically harmed another individual or small animal
□ hostile/angry mood	□ death in family	
□ chronic lying	□ move to a new place	□ run away from home
□ stealing	□ self-injurious acts	□ attempted suicide
□ violent temper	□ easily distracted	□ started a fire
□ not trustworthy	□ change of schools	□ None of the above

Primary Care Physician: _____
Current medications being taken: _____

Has your child had prior mental health services, counseling, and/or alcohol/drug treatment? If so, where and when? _____
_____
_____

Does your child have an eating or sleeping problem:

□ dieting
□ overeats
□ picky eater
□ recent weight gain
□ recent weight loss
□ difficulty falling asleep
□ nightmares
□ sleeps too much
□ trouble staying asleep
□ None of the Above

How would you rate your child's nutritional value and balance of diet:
□ Good □ Fair □ Poor

Has your child been diagnosed and/or currently being treated for any of the following: (check all that apply)

□ ADHD
□ Anemia
□ Asthma
□ Cancer/Leukemia
□ Diabetes
□ Ear infections
□ Hearing problems
□ Vision problems
□ Heart problems
□ HIV/AIDS
□ Loss of consciousness
□ Seizures
□ Other
□ None of the above

Comments: _____
_____
_____

Has your child ever experienced or witnessed:

□ domestic violence
□ emotional abuse
□ physical abuse
□ rape/sexual assault
□ sexual abuse
□ None of the Above
□ perpetrator of any abuse

Comments: _____
_____
_____
_____

EDUCATION

School presently attending_____ Grade _____
School related issues:

□ academic problems
□ advanced a grade
□ attendance
□ behavior
□ met with school counselor
□ peer relationships
□ relationship with teacher(s)
□ required special help

□ detention □ suspension/expulsion
□ held back a grade □ tested by school psychologist (ADD, ADHD, LD)
□ homework □ transportation
□ None of the Above
Comments: _____
_____
_____
_____

SOCIO-ECONOMIC HISTORY

Financial situation:

Are there family financial concerns? □ yes □ no
Comments: _____
_____
_____

Does your child have the opportunity to earn spending money? □ yes □ no
Comments: _____
_____
_____

Legal History:

Has your child ever had involvement with the legal system? □ yes □ no

Does your child have any current pending charges? □ yes □ no

Is he/she on probation? □ yes □ no

Has he/she ever been in detention/jail? □ yes □ no

Does your child have any gang involvement? □ yes □ no

Are there any legal problems having to do with other family members? □ yes □ no
Comments: _____
_____
_____

Sexual History:

To the best of your knowledge, you child/adolescent is:

Sexually active	□ yes	□ no	□ unknown
Uses contraceptives	□ yes	□ no	□ unknown
History of pregnancy	□ yes	□ no	□ unknown
History of abortion	□ yes	□ no	□ unknown
Fathered/mothered a child	□ yes	□ no	□ unknown

SUBSTANCE USE HISTORY

Substance	Age at 1st use	Recent frequency/ quantity/etc.	Date & amount of last use
Alcohol			
Marijuana			
Cocaine/Crack			
Hallucinogens (LSD, Acid, MDMA)			
Stimulants (Speed, Meth, diet pills)			
Anxiolytics (xanax, ativan, serax, etc.)			
Analgesics (Pain Meds)			
Heroin/Other			

What is your drug of choice? _____
When was your last use? _____

Consequences of your substance abuse (check all that apply)

□ hangovers	□ tolerance changes	□ arrests
□ stealing from family/friends	□ loss of control amount used	□ suicide impulses
□ blackouts	□ sleep disturbances	□ school problems
□ change in peers	□ assaults	□ mood swings
□ withdrawal symptoms	□ relationship conflicts	□ none of the above

Have others expressed concern about your child's alcohol/tobacco/drug use? □ yes □ no

Clinical Impression: _____
_____
_____
_____
_____
_____

Thank you for providing this information.

_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature	Date
_____	_____
Interviewer	Date