**Step Up Family Services**

*Every journey begins one step at a time*

# Social Skills Group Intake Packet

## Personal Information

Youth Name___________________________________ DOB: __________________ Age:______

Address: __________________________________________________________________________

Home Phone: ___________________________ Cell Phone:________________________________

Email: _______________________________________________ Gender: Female / Male / Other

Ethnicity: _______________________ Race: ___________________________________

Caregiver/Guardian Name: ___________________________ Caregiver/Guardian Relation:______________

Emergency Contact Name:____________________ Phone:____________________ Relation: __________

Interested in Sibling Empowerment Group: Yes / No

Sibling Name: ___________________________________________________ Age: _________

Sibling Name: ___________________________________________________ Age: _________

Sibling Name: ___________________________________________________ Age: _________

Sibling Name: ___________________________________________________ Age: _________

Interested in Caregiver Empowerment Group: Yes / No

Caregiver Name: ___________________________________________________

Caregiver Name: ___________________________________________________

Caregiver Name: ___________________________________________________

Caregiver Name: ___________________________________________________

## Medical History

Does your child have any previous or current mental health diagnoses? Yes / No

If yes, please list: ___________________________________________________________________________

Does your child have any preexisting medical condition(s)? Yes / No

If yes, please list: __________________________________________________________________________

Does your child currently take any medication(s)? Yes / No

If so, please list current medication(s) __________________________________________________________

Does your child have any allergies? Yes / No

Please list all allergies ((include medication, seasonal, foods, or any other allergy:):

______________________________________________________________________________________

Have you or an immediate family member received counseling in the past? Yes / No

Are you or an immediate family member currently seeking counseling? Yes / No

Are there any activities your child should not participate in due to medical issues:_______________________________________________________________________________

## Crisis Plan

1. What is a crisis (what does it look like)?

2. What are triggers that lead to a possible crisis?

3. What are some strategies that work in a crisis situation?

4. Who can be helpful and how are they helpful in a crisis situation (other than caregiver if applicable):
    a. Name:
    b. Contact information:

## Developmental

**Describe Youth's Gross Motor Functioning** (Ability to sit, stand, walk, etc)**:**

**Does youth require assistance or prompting with self-care** (eating, bathing, dressing, toileting, etc):

**Learning:**

**Cognitive** (Does youth have cognitive delays, is there a known IQ available):

**Learning disability** (Are there known learning disability? In what areas?):

**Developmental Delays** (what are the diagnosed developmental delays):

# Group Assessment

| | | | | |
|---|---|---|---|---|
| **1.** | **Have you attended any social groups in the past?** | | | YES/NO |
| **2.** | **I enjoy participating in group activities.** | | | YES/NO |
| **3.** | **Are you involved in any extracurricular activities?** | | | YES/NO |
| **4.** | **I respect the authority figures in my life.** | Always | Sometimes | Never |
| **5.** | **I am able to follow directions after given the first time.** | Always | Sometimes | Never |
| **6.** | **When I am upset, I am able to control myself.** | Always | Sometimes | Never |
| **7.** | **I am able to maintain eye contact during conversations.** | Always | Sometimes | Never |
| **8.** | **I am able to understand and respect others personal space.** | Always | Sometimes | Never |

**9.** **What is something that a peer does that might upset you?**

______________________________________________________________________________

**10.** **What are your interests or hobbies?**

______________________________________________________________________________

**Parental Consent**

**Thank you for choosing Step Up Family Services LLC for your child's therapy.**

**I, ___________________________________________, hereby give permission for Step Up Family Services LLC to provide therapy services to ________________________________.**

**Child's Name**

________________________________________ __________________ _________________

**Signature (Parent/Legal Guardian)** **Relationship** **Date**