#YOLO Intake Form
Youth Outreach. Learning & Overcoming

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Child information

Name:_____DOB_____

Address: _____

Phone #:_____

Email:_____

Parents/guardian information:

Name:_____DOB_____

Address: _____

Phone #:_____

Email:_____

Employment status: (circle one) Full time Part time Unemployed

Marital Status:_____

Name:_____DOB_____

Address: _____

Phone #:_____

Email:_____

Employment status: (circle one) Full time Part time Unemployed

Marital Status:_____

Child's Legal Status:

Parents, no custody arrangements

Joint custody

Sole custody Name:_____

Ward of the state

Case workers name:_____ Phone #:_____

Child's Scool Information

Name of school:_____

Address:_____

Contact person if applicable:_____

Special education?:_____ Has IEP?:_____

Medical History

Child's Physician Name:_____ Number:_____

Medical conditions and/or symptoms:_____

_____

Medications currently taking:_____

_____

Allergies:_____

Any religious, spiritual, or cultural beliefs that may conflict with activities?

_____

_____

Has anyone in the family experienced the following?

____Depression	____Imprisonment	____Suicide or attempts
____Anxiety	____Schizophrenia	____Drug abuse
____Alcohol abuse	____Child abuse	____Physical abuse
____Sexual abuse	____Neglect	____Other (explain):

_____

_____

Symptoms

Please check symptoms your child is experiencing or has recently experienced:

____Mood swings	____Physical violence	____Hopeless thinking
____Too little sleep	____Too much sleep	____Unsure of reality
____Desire to die	____Extreme anger	____Lack of energy
____Guilty feelings	____Confusion	____Excess energy
____Low self esteem	____Suicide attempts	____Panic attacks
____Drug abuse	____School difficulties	____Stomach aches
____Alcohol abuse	____Unsure of identity	____Memory loss
____Vomiting	____Headaches	____Slowed thinking
____Bed wetting	____Fluctuation in weight	____Other: (explain)

_____

_____

Child interests

____Art	____Music	____Sports
____Reading	____Photography	____Crafts
____Leaderahip	____Skateboarding	____Fashion
____Instruments	____Cars	____Sewing
____Cooking	____Poetry	____Working out
____Gardening	____Swimming	____Potery
____Fishing	____Hiking	____Video games
____Biking	____Singing	____Acting
____Dancing	____Computers	____Movies

Other:

_____

_____

Has your child been to counseling or currently in counseling?

_____

Any other information you feel is important forus to know?

_____

_____

How did you hear about our services?

_____