HOPELIFE BEHAVIORAL AND WELLNESS, LLC

ADOLESCENT/YOUNG ADULT INTAKE FORM

(CLIENT SECTION)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Male\_\_\_\_\_ Female\_\_\_\_\_\_ Race/ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Messages/text okay? Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade/Year: \_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful at? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are 3 positive qualities about yourself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who are influential and supportive people in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT REASON FOR SEEKING THERAPY

Briefly describe the problem for which you are seeking help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to see happen as a result of therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MENTAL HEALTH HISTORY

Have you previously seen a therapist? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_

Inpatient \_\_\_\_\_Outpatient\_\_\_\_\_\_\_ Where/when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what did you find most helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you find least helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSTANCE USE AND HISTORY

Do you currently use alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, how often do you drink? Daily \_\_\_\_\_\_Weekly \_\_\_\_\_Occasionally \_\_\_\_\_Rarely \_\_\_\_\_\_\_

If yes, how much do you drink? \_\_\_\_\_\_\_\_\_\_\_\_ (#) per time.

Do you currently use tobacco? Yes \_\_\_\_\_No \_\_\_\_\_\_ If yes, how much do you smoke? \_\_\_\_\_\_\_

Do you currently use any drugs? Yes \_\_\_\_\_\_No \_\_\_\_\_\_\_

If yes, what drugs do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how often do you use? Daily\_\_\_\_\_ Weekly \_\_\_\_\_\_Occasionally \_\_\_\_\_Rarely \_\_\_\_\_\_\_\_

Have you ever used more than 1 substance at the same time to get high? \_\_\_\_\_\_\_\_\_

Do you miss activities so you can use? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Do you miss school because of it? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Do you have friends who use? Yes \_\_\_\_\_\_\_ No\_\_\_\_\_\_

Do you use to improve/manage your emotions such as sad or depressed? Yes\_\_\_\_\_ No \_\_\_\_\_\_\_

Have you received any previous treatment for substance use? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inpatient \_\_\_\_\_Outpatient \_\_\_\_\_\_ When\_\_\_\_\_\_\_\_

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present or in the past \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

Are your parents married or divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think their relationship is good? Yes\_\_\_\_\_ No \_\_\_\_\_ Unsure \_\_\_\_\_

If your parents are divorced, whom do you primarily live with? \_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you see each parent? Mom\_\_\_\_\_\_\_\_\_% Dad \_\_\_\_\_\_\_\_\_\_\_%.

Are you now or have in the past experienced any abuse in your home or outside your home (physical, verbal, emotional or sexual)? Please describe as much as you feel comfortable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any trauma? If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

|  |  |  |  |
| --- | --- | --- | --- |
| Concern | Yes | No | Details |
| Substance Use |  |  |  |
| Abuse/Neglect |  |  |  |
| Domestic Violence/Physical Fights |  |  |  |
| Financial Problems |  |  |  |
| Unstable Housing |  |  |  |
| Mental Health Issues |  |  |  |
| Death of a Significant Family Member |  |  |  |
| Parental Divorce/Separation |  |  |  |

Other Concerns not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PEER RELATIONS

How do you consider yourself socially: outgoing \_\_\_\_shy \_\_\_\_depends on the situation\_\_\_\_\_

Are you happy with the amount of friends you have? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Have you ever been bullied? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Do your parents like your friends? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

Are you involved in any organized social activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: Heterosexual \_\_\_\_ Homosexual \_\_\_\_ Bisexual \_\_\_\_ Choose not to answer

Are you sexually active? Yes \_\_\_\_\_ No \_\_\_\_\_ Choose not to answer \_\_\_\_\_

Are you currently in a relationship? Yes \_\_\_\_\_ No \_\_\_\_\_

SCHOOL HISTORY

Do you like school? Yes\_\_\_\_\_ No\_\_\_\_\_\_ Do you attend regularly? Yes\_\_\_\_\_ No\_\_\_\_\_\_

What are your current grades? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you are doing the best you can in school? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_

INDIVIDUAL CONCERNS (check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Problem sleeping |  |  | Depressed mood |  |  |
| Suicidal ideation |  |  | Self-Injurious behavior |  |  |
| Elevated mood |  |  | Hopelessness |  |  |
| Anxiety |  |  | Aggression |  |  |
| Repetitive behaviors or thoughts |  |  | Feeling that your thoughts are controlled |  |  |
| Sadness, crying often |  |  | Helplessness |  |  |
| Mood swings |  |  | Hearing voices when no one else present |  |  |
| Irritability |  |  | Difficulty leaving house |  |  |
| Change in eating/appetite |  |  | Binging/purging |  |  |
| Increased/decreased energy |  |  | Feeling isolated/lonely |  |  |
| Frequent worry |  |  | Racing thoughts |  |  |
| Intrusive memories |  |  | Feeling numb |  |  |
| Difficulty concentrating |  |  | Flashbacks |  |  |
| Thoughts of harming self |  |  | Thoughts of harming others |  |  |
| Seeing things other people don’t see |  |  | Anger outburst |  |  |
| Feeling that the TV or radio are communicating with you |  |  | Concerns about your sexuality |  |  |

Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Confidentiality Agreement: We would like you to know that we have worked with many adolescents/young adults and that we respect your privacy. Your communications with us are confidential with the exception of reports of abuse and intent to harm self or others.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

HOPELIFE BEHAVIORAL AND WELLNESS, LLC

ADOLESCENT/YOUNG ADULT INTAKE FORM

(PARENT SECTION)

Adolescent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_ Female\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race/Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address where adolescent resides \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Cell# (indicate if mother or father) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best # to contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message/text? Yes\_\_\_\_ No\_\_\_\_\_\_

Responsible Party

Name of responsible party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of Issue\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information: *(Please provide a copy of your photo ID / license and front and back of insurance card)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Insured: |  | Relationship to Client: |  |
| Insurance Company: |  | Group # |  |
| Policy/I. D# |  | Copay: |  |

Do you have secondary? (if yes, check the box and complete the information below)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Insured: |  | Relationship to Patient: |  |
| Insurance Company: |  | Group # |  |
| Policy/I. D# |  | Copay: |  |

Is your family involved with DCF? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(we will not contact DCF without your permission/request, unless a report of abuse is required)

CURRENT FAMILY AND HOUSEHOLD INFORMATION (adults and children)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Relationship to client (parent, sibling, etc) | Age | Sex | Type  (bio, step, etc) | Living In Home  Y/N |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Current reason for seeking counseling for your adolescent (Briefly describe the problem, including when first started)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to see happen as a result of counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is most concerning right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR ADOLESCENT’S STRENGTHS

What positive qualities would you say your son or daughter has? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child? Yes \_\_\_\_ No \_\_\_\_\_

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have health problems at birth? Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes \_\_\_ No \_\_\_ Not sure\_\_\_\_\_

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child have any unusual or problem behaviors prior adolescence? Yes \_\_\_\_\_ No \_\_\_\_\_

Not sure\_\_\_\_\_ If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child experienced neglect, emotional, physical, or sexual abuse?

Yes \_\_\_\_ No \_\_\_\_ Not sure \_\_\_\_\_ If yes, describe including type of abuse, by whom and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child experienced trauma? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_ If yes, please describe:\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MENTAL HEALTH HISTORY

Has your son or daughter previously seen a therapist? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

If Yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what reason did your son or daughter go to therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your son or daughter have a mental health diagnosis? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

If yes, please note\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you find therapy was helpful for your son/daughter Yes \_\_\_\_\_ No\_\_\_\_\_\_

What was most and least helpful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is/has your son or daughter used psychiatric services? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_

If yes, who did they see/when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, was it helpful? N/A\_\_\_\_ Yes\_\_\_\_ No\_\_\_\_\_\_

Does your son/daughter currently take medication for mental health issues? Yes\_\_\_\_ No \_\_\_\_\_

If yes, prescriber (name/phone #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/dose of medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your son/daughter take the medications consistently/as prescribed? Yes\_\_\_\_\_\_ No \_\_\_\_\_

Does your son/daughter have any medical conditions that may be impacting their daily functioning? Yes \_\_\_\_ No\_\_\_\_ If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSTANCE USE

Do you have any concerns with your son/daughter using alcohol or drugs? Yes\_\_\_\_ No \_\_\_\_

If yes, please explain your concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter’s use of the internet or electronic communication such as Facebook, Twitter, texting etc? Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, please explain your concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present or in the past \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

Has your son or daughter experienced any trauma or abuse? (if yes, please include type, by whom and when) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there intergenerational abuse in your family?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is domestic violence an issue in your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENTS’ INFORMATION AND MARITAL STATUS

Father: Age\_\_\_\_\_\_\_\_\_\_\_\_ Race/ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_ Combat experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Status: Single \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Separated \_\_\_\_\_Widowed \_\_\_\_\_

Mother: Age\_\_\_\_\_\_\_\_\_\_\_\_ Race/ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_ Combat experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Status: Single \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Separated \_\_\_\_\_Widowed \_\_\_\_\_

Length of marriage/relationship of parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If separated/divorced, how old was your son/daughter at the time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for separation/divorce: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your son/daughter’s reaction to the separation/divorce? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If divorced/separated, how much time does your son/daughter spend with each? Mother\_\_\_\_\_\_\_%, Father \_\_\_\_\_%

Assessment of current relationship : Poor\_\_\_\_\_\_ Fair\_\_\_\_\_\_\_ Good\_\_\_\_\_\_\_\_ Excellent\_\_\_\_\_\_\_

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

|  |  |  |  |
| --- | --- | --- | --- |
| Concern | Yes | No | Details |
| Substance Use |  |  |  |
| Abuse/Neglect |  |  |  |
| Domestic Violence/Physical Fights |  |  |  |
| Financial Problems |  |  |  |
| Unstable Housing |  |  |  |
| Excessive Arguing |  |  |  |
| Mental Health Issues |  |  |  |
| Death of a Significant Family Member |  |  |  |
| Parental Divorce/Separation |  |  |  |

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to your child (e.g. father, grandmother, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| Mental History | Yes/No | If yes, list family member |
| Alcohol/Substance Use |  |  |
| Anxiety |  |  |
| Depression |  |  |
| Domestic Violence |  |  |
| Eating Disorder |  |  |
| PTSD/Anxiety |  |  |
| Obsessive Compulsive Behavior |  |  |
| Schizophrenia |  |  |
| Suicide |  |  |
| Suicide Attempts |  |  |
| Self-injurious Behavior |  |  |
| Mood Disorders |  |  |
| Personality Disorders |  |  |
| ADHD |  |  |
| Psychiatric hospitalizations |  |  |

FAMILY MEDICAL HISTORY

Please indicate any significant current/past family members’ medical conditions that may have/be impacting your son/daughter\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MENTAL HEALTH: Have you observed or has your son/daughter reported any of the following? (check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Problem sleeping |  |  | Depressed mood |  |  |
| Suicidal ideation |  |  | Self-Injurious behavior |  |  |
| Elevated mood |  |  | Hopelessness |  |  |
| Anxiety |  |  | Aggression |  |  |
| Repetitive behaviors or thoughts |  |  | Feeling that your thoughts are controlled |  |  |
| Sadness, crying often |  |  | Helplessness |  |  |
| Mood swings |  |  | Hearing voices when no one else present |  |  |
| Irritability |  |  | Difficulty leaving house |  |  |
| Change in eating/appetite |  |  | Binging/purging |  |  |
| Increased/decreased energy |  |  | Feeling isolated/lonely |  |  |
| Frequent worry |  |  | Racing thoughts |  |  |
| Intrusive memories |  |  | Feeling numb |  |  |
| Difficulty concentrating |  |  | Flashbacks |  |  |
| Thoughts of harming self |  |  | Thoughts of harming others |  |  |
| Seeing things other people don’t see |  |  | Anger outburst |  |  |
| Feeling that the TV or radio are communicating with you |  |  | Concerns about your sexuality |  |  |

Other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Confidentiality Notice for Parents

Your son/daughter has the right to private, confidential communication with their APRN, therapist and treatment team. This means that we will not disclose information to anyone, including you, unless we have been given their permission. We need your son/daughter to be open and honest in order to understand and treat the issues your son/daughter is dealing with. The only exception to the above is if your son/daughter reports abuse (Hopelife staff are mandated reports) and intent to harm self or others.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature Date