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Youth Intake Form

Youth's name:_____ Today's Date:_____

Birthdate:_____ Age:_____ Gender: _____M _____F

Home Address:_____ Phone (home):_____

_____ Phone (cell):_____

Person filling out this form (circle): Mother Father Stepmother Stepfather Other:_____

Marital status of parents:_____Who has legal guardianship of your child?_____

If parents are separated or divorced, how old was the child when the separation occurred?_____

Mother's name:_____ Age:_____

Education:_____ Occupation:_____

Phone: Home:_____ Work:_____ Cell:_____

Father's name:_____ Age:_____

Education:_____ Occupation:_____

Phone: Home:_____ Work:_____ Cell:_____

Stepparent's name:_____ Age:_____

Education:_____ Occupation:_____

Phone: Home:_____ Work:_____ Cell:_____

Who does your child currently live with?

Names	**Relationship to child**	**Age**

Who are your child's siblings/significant others NOT living with your child?

Names	**Relationship to child**	**Age**

Primary language spoken in the home:

Other languages spoken in the home:

Family History:

Please describe any past counseling that either your child or any family member has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? **Y N**
If yes, please describe:

Does anyone in the child's family have psychological or emotional difficulties? **Y N**
If yes, please list below:

Names	**Relationship to child**	**Difficulties (describe)**

Please provide the following information about your child:

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does s/he do that other people like?

Other Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST? How much must they change for you to be satisfied?

Education History:

What school does your child attend?

Address:

Teachers Name: Current Grade:

What does your child's teacher say about him/her?

Other schools attended (including Pre-school):

Has your child ever repeated a grade? **Y N** If so, which one(s)?

Has your child ever received special education services? **Y N** If so, please list:

Has your child experienced any of the following problems at school? (Circle all that apply)

lack of friends	drug/alcohol	detention	suspension
learning disabilities	poor attendance	poor grades	gang influence
fighting	incomplete homework	behavior problems	

other (list):

Medical History:

What is the name of your child's medical doctor?

Address: Phone:

Date of your child's last medical examination:

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during pregnancy? **Y N**
If so, please list:

Did the child's mother have any problems during the pregnancy or at delivery? **Y N** If yes, please describe:

Were forceps used during delivery?

How long did labor/delivery take?

Was a Caesarean section performed? If yes, for what reason?

Was the child premature? If so, by how many months?

What was the child's birth weight?

Were there any birth defects or complications? If yes, please describe:

Were there any feeding problems? If yes, please describe:

Were there any sleeping problems? If yes, please describe:_____

_____

As an infant, was the child quiet?_____

As an infant, did the child like to be held?_____

As an infant, was the child alert?_____

Were there any special problems in the growth and development of the child during the first few years? If yes, please describe:_____

_____

_____

The following is a list of infant and preschool behaviors. Please indicate that age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	*Age*	*Behavior*	*Age*
Showed response to mother	_____	Put several words together	_____
Rolled over	_____	Dressed self	_____
Sat alone	_____	Became toilet trained	_____
Crawled	_____	Stayed dry at night	_____
Walked alone	_____	Fed self	_____
Babbled	_____	Rode tricycle	_____
Spoke first word	_____		

Has your child experienced any of the following medical problems?

serious accident	hospitalization	surgery	asthma
head injury	high fever	meningitis	convulsions/seizures
eye/ear problems	hearing problems	allergies	loss of consciousness

other (list):_____

Please list any current medical problems or physical handicaps:

_____

_____

_____

_____

Please list any medications your child takes on a regular basis:

_____

_____

_____

_____

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal)? **Y N** If yes, please describe:

_____

_____

_____

Has your child ever mentioned wanting to hurt him/herself or seriously hurt someone else? **Y N**
If yes, please describe:_____

_____

_____

Has he/she ever purposely hurt himself or another? **Y N** If yes, please describe:

_____

_____

_____

Has your child ever experienced any serious emotional losses (such as a death of a parent/caretaker, physical separation from a parent/caretaker, divorce, etc.)? **Y N** If yes, please describe:

_____

_____

_____

Please place a check next to any behavior or problem that your child currently exhibits.

Check

_____ Has difficulty with speech
_____ Has difficulty with hearing
_____ Has difficulty with language
_____ Has difficulty with vision
_____ Has difficulty with coordination
_____ Prefers to be alone
_____ Does not get along well with brothers and sisters
_____ Is aggressive
_____ Is shy or timid
_____ Is more interested in things (objects) than in people
_____ Engages in behavior that could be

Check

_____ Has frequent tantrums
_____ Has frequent nightmares
_____ Has trouble sleeping
(describe)_____
_____
_____ Rocks back and forth
_____ Bangs head
_____ Holds breath
_____ Eats poorly
_____ Is stubborn
_____ Has poor bowel control (soils self)
_____ Bites nails
_____ Is much too active

dangerous to self or others (describe)
_____
_____

_____ Has special fears, habits, or mannerisms (describe)_____
_____

_____ Wets bed
_____ Sucks thumb
_____ Is clumsy
_____ Has blank spells
_____ Is impulsive
_____ Shows daredevil behavior
_____ Is slow to learn
_____ Gives up easily
_____ Other (describe)_____
_____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to <u>each</u> technique that you usually use.

Check	*Disciplinary technique*	*Check*	*Disciplinary technique*
_____	Ignore problem behavior	_____	Tell child to sit on chair
_____	Scold child	_____	Send child to his/her room
_____	Take away some activity or food	_____	Spank child
_____	Threaten child	_____	Other (describe)_____
_____	Reason with child		_____
_____	Redirect child's interest	_____	Don't use any technique

Which disciplinary techniques are usually effective?_____

_____

With what types of problem(s)?_____

_____

Which disciplinary techniques are usually ineffective?_____

_____

With what types of problem(s)?_____

_____

What have you found to be the most satisfactory ways of helping your child?_____

_____

_____

Is there any other information that you think may help us in working with your child?_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

Updated 12/23/19