Chart #_____

Catholic Social Services of the U.P.

ADOLESCENT/CHILD INTAKE/FACE SHEET

The following information will assist your therapist in helping you. If you have any questions while completing this form, or are uncomfortable answering any part of the form, feel free to skip that part and ask your therapist about it.

Name_____ Age: _____ Date _____
Last First Middle Initial

Person completing form (if not the client) _____Relationship _____

Address_____ Phone # _____
Street City State Zip Code

Living Situation (Check) ____ Stable ___ Unstable ___ Homeless

Comments_____

SS # _____ DOB ___/___/___ Guardian Work Phone: _____

Birthplace _____Name of School _____Religion_____

Ethnic Group: Caucasian _____ Native American_____ Asian _____ African-American _____

Hispanic ___ Other _____ Are you a member of a tribe? _____ If so, which one? _____

Name of your family doctor _____ Phone # _____

Emergency Contact Person: Name _____Phone # _____

Allergies: _____

Household Members	**Relationship**	**Birthdate**	**Place**	**Education**
_____	_____	_____ Age	_____	_____
_____	_____	_____ Age	_____	_____
_____	_____	_____ Age	_____	_____
_____	_____	_____ Age	_____	_____
_____	_____	_____ Age	_____	_____
_____	_____	_____ Age	_____	_____

Adolescent/Child Social History Questionnaire

The following information will assist your therapist in helping you. If you have any questions while completing this form, or uncomfortable answering any part of the form, feel free to skip that part and ask your therapist about it.

NAME _____ DATE _____

OUTSIDE RESOURCES:

1) Have you ever received mental health services in the past? _____ No _____ Yes (If Yes, please indicate where and when) _____

Please list the name(s) of individuals you would like us to contact whom you have seen or are presently involved with (Therapist/ School Psychologist/Social Worker/Counselor):

_____

_____

2) Are you experiencing difficulty in any of the following areas? Please check those that apply to you.

_____ Anger
_____ Anxiety
_____ Bad dreams
_____ Feelings easily hurt
_____ Frequent crying
_____ Hallucinations
_____ Mood swings
_____ Panic Attacks
_____Spiritual concerns
_____ Feelings of hopelessness
_____ Lack of assertiveness
_____Suicidal thoughts/feelings
_____ Substance abuse concerns

_____ Guilt/shame
_____ Family problems
_____ Fantasies of Violence
_____ Homicidal thoughts
_____ Resists authority
_____ Bed wetting
_____ Obsessive thoughts
_____ Aggression
_____Health concerns
_____ Physical abuse
_____ Low self-esteem
_____Rape/sexual abuse
_____ Other

_____ Insecurity
_____ Loneliness
_____ Irritability
_____ Nervousness
_____Weight loss
_____ Weight gain
_____ Fatigue
_____ Gambling
_____ Jealousy
_____ Hard to trust others
_____ Dependency

3) Which of the above difficulties would you like help with?_____

_____

_____

_____

4) Do you gamble? _____ Yes _____ No

5) Have you ever felt the need to bet more and more money? _____ Yes _____ No

6) Have you ever had to lie to people important to you about how much you gambled? ____Yes ____ No

7) Have you ever been treated for any of the following conditions? **P = Past** **C = Current**

__ Alcohol Abuse	__ Anemia	__ Arthritis
__ Other Drug Abuse	__ Cancer	__ Hearing Problems
__ Chronic Pain	__ Convulsions	__ Diabetes
__ Asthma	__ High Blood Sugar	__ Epilepsy
__ G.I. Problem	__ Seizures	__ Venereal Disease
__ Heart Disease	__ Dental Problems	__ Heart Injury
__ High Blood Pressure	__ Kidney Problems	__ Liver Problems
__ Menstrual Problems	__ Low Blood Sugar	__ Malaria
__ Rheumatic Fever	__ Meningitis	__ Migraines
__ Ulcers	__ Vision Problems	__ Thyroid
__ IV Drug Use	__ Blackouts	__ Cerebral Palsy
__ Others:_____		

8) Have you ever been hospitalized? ___ No ____Yes (If yes, list dates) _____

_____

9) Have you ever been prescribed psychiatric medications? _____ Yes _____ No

10) Are you using any specific anti-convulsant drugs? _____ If yes, please list:

_____

11) Do you have all the required immunizations for your age? _____ Yes _____ No

MEDICATIONS:

12) Are you on any medications at this time? ___ No ____Yes (if yes, please fill in box below)

Medication	Amount	Prescribing Physician	Medication Taken As Prescribed?
			_____ Yes _____ No
			_____ Yes _____ No
			_____ Yes _____ No
			_____ Yes _____ No

ALCOHOL AND OTHER DRUG USE HISTORY:

13) To help us in understanding your situation, it is helpful if your counselors know about your use of alcohol and drugs. Your answers will be kept private. Circle the answer that best describes your use.

Have you used alcohol at all in the past month? Yes No

How many times in the past month have you had five or more drinks on one occasion?

(A drink is one shot of liquor, 12 ounces of beer, or 5 ounces of wine.)

Never 1-2 Times 3-4 Times 5 Times More than 5 Times

Have you used any of the following kinds of drugs? (Check the boxes that apply to you.)

	Never Used	**Not used in more than a year**	**Used in Past Year**	**Used in Past Month**	**Used in Past 48 Hours**
Marijuana					
Cocaine/Crack					
Hallucinogens					
Amphetamines					
Inhalants					
Heroin					
Other Drugs					

Have you ever gone to a support group such as Alcoholics Anonymous SMART, or Narcotics Anonymous because of an alcohol or other drug problem? Yes No

Have you ever had counseling or treatment for an alcohol or other drug problem? Yes No

When? Where?

_____ _____

_____ _____

_____ _____

Have you ever spent more time drinking or using drugs than you intended? Yes No

Have you ever neglected some of your usual responsibilities because of using alcohol or drugs? Yes No

Have you ever wanted to cut down on your drinking or drug use? Yes No

Have anyone ever objected to your drinking or drug use? Yes No

Have you ever been preoccupied with drinking or using drugs? That is, have you ever found yourself thinking a lot about drinking or using? Yes No

Have you ever used alcohol or drugs to ease emotional discomfort such as sadness, anger, or boredom? Yes No

Do you smoke tobacco? Yes No

Do you chew tobacco? Yes No

MEDICAL HISTORY:

14) What is the date of your last FULL physical exam: _____

15) Have you ever been told you have Tuberculosis? _____ Yes _____ No

16) Have you ever been told you have Hepatitis A, B, or C? _____ Yes _____ No

17) Have you ever been tested for HIV? _____ Yes _____ No

FAMILY OF ORIGIN:

18) Who raised you? _____

Parent's Present Status	Mother	Father	Step-Mother	Step-Father	Other
Alive (Present Age)					
Deceased (Age)					
Year of Death					
Cause					
Occupation					

19) What are your brothers/sisters first names and ages? _____

_____

20) What is your current relationship with your sisters/brothers? ____Good _____Fair _____Poor

21) Who in your family do you feel closest to? _____In what way?_____

_____

22) Have you ever not lived with your family? _____ No _____ Yes (if yes, why)_____

_____

23) Is there anything from your childhood that has been traumatic? Please describe:

_____

_____

24) What events or things do you enjoy?_____

_____

25) Are you adopted or a foster child? _____ Adopted _____ Foster Child _____ N/A

26) On what date did this occur? _____

27) Do you have any family members with mental illness or developmental disabilities?

Relationship	Illness/Disability	Comments (symptoms, severity, etc.)

RELATIONSHIP HISTORY:

28) How well do you get along with other people? _____Good _____ Fair _____ Poor

29) Have your friendships changed recently? _____ No _____ Yes (If yes, how?)

_____

30) Are you happy with your current friendships? _____ No _____ Yes

31) If close relationships have ended, what were the reasons? _____

_____

32) What do you do for fun (sports, band, computer games, etc.)? _____

_____

DEVELOPMENTAL HISTORY:

33) The following questions are about your mother's pregnancy with you.

Pregnancy Duration: Early ___ On-Time ___ Late ___

a. Complications: (Please circle)

Excessive vomiting	Staining/blood loss	Hospitalization/bed rest
Threatened miscarriage	Toxemia	Smoking during pregnancy
Infections	Operations	Alcohol consumption
Other illnesses	Drugs taken	

34) When you were younger, did you have any problems with:

Walking _____ Yes _____ No

Talking _____ Yes _____ No

Hearing _____ Yes _____ No

Seeing _____ Yes _____ No

35) Do you have any of these problems now? _____ Yes _____ No

EDUCATION HISTORY:

36) What grade are you in?_____ Name of current school: _____

37) Are you in special education? ____ No _____ Yes (If yes, describe:) _____

_____

38) Do you ever have difficulties in school? _____ No _____ Yes (If yes, describe the type of difficulty:)

_____

39) What are your educational goals?_____

40) School Related Behavior — Please Circle

Do you have difficulty paying attention in class?	Yes	No
Do you have problems with grades?	Yes	No
Have you been recommended for special services?	Yes	No
Are you ever afraid to go to school?	Yes	No
Have you ever repeated a grade?	Yes	No
Do you have behavior problems in class?	Yes	No
Do you have difficulty making friends at school?	Yes	No
Do you complain of health problems to stay home?	Yes	No
Do you skip school?	Yes	No

WORK HISTORY:

41) Who is your current employer or volunteer work place? _____

42) What type of work do you do?_____Length of Service: _____

43) Are you happy with your work? _____ Yes _____ No

44) What are your future career goals? _____

LEGAL HISTORY:

45) Have you been involved with: (Check all that apply) ___ Probation ____ Parole ____ Probate Court?

If so, describe: _____

Probation/Parole Officer: _____

46) Are the services you are currently seeking court ordered? __ No ___Yes (If yes, by whom:)

_____

47) Other important information you would like us to know: _____

_____

48) Why are you requesting counseling? Please write a brief statement explaining your difficulty.

_____

_____

_____

Reviewed with: _____ Date: _____

Client's name

_____

Clinician Signature

THANK YOU! PLEASE FEEL FREE TO TALK WITH YOUR THERAPIST ABOUT ANY PART OF THIS FORM!