CHILD/ADOLESCENT INTAKE

General Instructions

Please fill out these forms as fully and openly as possible. This information is helpful to ensure an accurate assessment, which will assist us in making appropriate diagnostic decisions and recommendations. Please feel free to attach any additional information that you think might help us better understand the child/adolescent (i.e., past psychological reports, etc.). We appreciate your cooperation and willingness to complete these forms prior to the initial appointment.

When completing these forms, please consider the following:

- Please read the questions carefully and answer them in full. Please ask for clarification if you do not understand an item.
- Write as legibly as possible.
- The child/adolescent's parent/guardian and/or the child/adolescent should complete the forms.
- Please understand that this information is for evaluation, intervention, and recommendation purposes. The information you provide will be part of the evaluation. If there are specific details that you are hesitant in sharing, please bring these issues to our attention during your appointment.

Thank you in advance for completing these forms.

Child, Youth & Family Mental Wellness

CHILD/ADOLESCENT INTAKE

Today's Date: / /

INFORMATION REGARDING THE INDIVIDUAL COMPLETING THIS FORM

Who is giving this information? ☐ CHILD/ADOLESCENT ☐ PARENT/GUARDIAN/CAREGIVER ☐ BOTH

Name:	**Relationship to child:**
Name:	**Relationship to child:**

CHILD/ADOLESCENT (CLIENT) INFORMATION

Full Legal Name: [FIRST] [MIDDLE] [LAST]

Nickname/Preferred Name (if applicable):			**Date of Birth:** / /	**Age:**
Sex assigned at birth:	☐ FEMALE ☐ MALE	☐ NOT RECORDED ON BIRTH CERTIFICATE	☐ CHOOSE NOT TO DISCLOSE ☐ UNKNOWN	☐ UNCERTAIN
Current gender:	☐ FEMALE ☐ MALE	☐ TRANSGENDER FEMALE ☐ TRANSGENDER MALE	☐ CHOOSE NOT TO DISCLOSE ☐ UNKNOWN	☐ OTHER/NON-BINARY: _____
Preferred pronouns:	☐ SHE/HER/HERS ☐ HE/HIM/HIS	☐ THEY/THEM/THEIRS ☐ CHILD/ADOLESCENT'S NAME	☐ CHOOSE NOT TO DISLOSE ☐ UNKNOWN	☐ OTHER: _____

Presenting Issues and Goals

PRESENTING ISSUES

What brings you here today? Who or what prompted you to seek services? (include symptoms, precipitating events or referrals)

How severe, on a scale of 1-10 (with 10 being the most severe), do you rate the child/adolescent's presenting problem (stated above)? (circle one)

LEAST SEVERE (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) MOST SEVERE

How long has this problem/these problems been causing the child/adolescent distress?

☐ LESS THAN 1 MONTH
☐ 1-6 MONTHS
☐ 6 MONTHS – 1 YEAR
☐ LONGER THAN 1 YEAR

What areas of functioning is this problem/difficulty affecting?

☐ BASIC NEEDS/SELF CARE
☐ CRIME/DELINQUENCY
☐ FAMILY/RELATIONSHIPS
☐ HOBBIES
☐ HOME/LIVING SITUATION
☐ PHYSICAL/MEDICAL
☐ SCHOOL/LEARNING (achievement, behavior, attendance)
☐ SEXUAL DEVELOPMENT
☐ SLEEP
☐ WORK
☐ OTHER: _____

GOALS FOR SERVICES

What are the goals for mental health services?

How will you know when services are complete?

What are the child/adolescent's strengths (personality traits, skills, etc.)? What strengths does client/adolescent have that will help them reach their goals?

What does the child/adolescent do to cope with their problems/difficulties?

☐ EXERCISE	☐ PLAYS VIDEO/COMP. GAMES	☐ TIME ALONE	☐ OTHER: _____
☐ LISTEN/PLAY MUSIC	☐ READ	☐ WATCH TV/MOVIES	
☐ MAKE ART	☐ TALK TO FRIEND/FAMILY	☐ WRITING	
☐ PLAY WITH A PET	☐ TAKE BATH/SHOWER	☐ UNKNOWN	

Child's Mental Health Treatment History

Has the child/adolescent ever been diagnosed with a mental health, emotional, or psychological condition?

☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (diagnosis given, when, by whom):

Has the child/adolescent ever had any emergency room visits for emotional or behavioral problems?

☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (reason, date, outcome, and name of hospital):

Past or current mental health treatment? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE COMPLETE TABLE BELOW.

TYPE OF TREATMENT	DATE(S)	PROVIDER/CLINIC NAME	DIAGNOSES/REASON
☐ OUTPATIENT MENTAL HEALTH TREATMENT			
☐ INPATIENT MENTAL HEALTH HOSPITALIZATION			
☐ OTHER (i.e., CLIP, residential): _____			

COMMENT ON CHILD/ADOLESCENT'S MENTAL HEALTH HISTORY (describe further if needed):

Child's Substance Use Disorder & Problem Gambling Treatment History

Past or current substance use disorder treatment? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE COMPLETE TABLE BELOW.

TYPE OF TREATMENT	DATE(S)	PROVIDER/CLINIC NAME	DIAGNOSES/REASON
☐ OUTPATIENT SUBSTANCE USE DISORDER TREATMENT			
☐ INPATIENT TREATMENT FOR DRUGS/ALCOHOL			
☐ OTHER (i.e., detox, relapse prevention): _____			

Past or current problem gambling treatment? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (dates, provider/clinic name, diagnoses/reason):

COMMENT ON CHILD/ADOLESCENT'S SUBSTANCE USE DISORDER OR PROBLEM GAMBLING TREATMENT HISTORY (describe further if needed):

CLIENT NAME/DOB/MRN (or affix label)

Child's Medical History

MEDICAL ISSUES/CONCERNS & TREATMENT

Primary Care Provider Name (i.e., pediatrician, nurse practitioner):

Other Medical Providers Name(s):

If it has been more than one year since the child/adolescent's last physical exam, we recommend scheduling an appointment with their doctor or health care provider. We also recommend routine vision and dental appointments whenever possible. Please tell your clinician if you need assistance in this area.

How would you describe the child/adolescent's overall physical health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Does the child/adolescent have any allergies? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, WHAT ARE THEY ALLERGIC TO? _____ WHAT IS THE REACTION? _____

Current significant medical concerns or problems? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Does the child/adolescent have a history of any of the following medical conditions/injuries or chronic health problems? (check all that apply):

☐ ASTHMA	☐ HEARING PROBLEMS	☐ LOSS OF CONSCIOUSNESS (after an accident)	☐ NO
☐ BLACKOUTS	☐ HEART CONDITION		☐ UNKNOWN
☐ DIABETES	☐ HIGH FEVERS (over 103° F.)	☐ SEIZURES (convulsions)	☐ OTHER
☐ HEAD INJURY	☐ POISONING OR OVERDOSE	☐ VISION PROBLEMS	_____

Has the child/adolescent ever had a surgery or procedure? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Any concerns or difficulties with the child/adolescent's hygiene? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Is child/adolescent currently receiving treatment for any medical conditions? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE COMPLETE TABLE BELOW.

MEDICAL CONDITION	DATE(S)	PROVIDER/CLINIC NAME	TREATMENT/RESPONSES

COMMENT ON CHILD/ADOLESCENT'S MEDICAL HISTORY (describe further if needed):

MEDICATIONS

Any currently prescribed and/or over-the-counter medications/supplements? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE COMPLETE TABLE BELOW.

MEDICATION NAME	DOSE	PRESCRIBER (IF APPLICABLE)	REASON	SIDE EFFECTS

Is the child/adolescent taking the medications as prescribed?

☐ YES ☐ NO ☐ UNKNOWN ☐ N/A

IF NO, PLEASE EXPLAIN: _____

Has the child/adolescent ever been prescribed psychiatric medication (not listed in the table above)? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (medication names, doses, etc.):

_____

CLIENT NAME/DOB/MRN (or affix label)

Family Psychiatric/Medical History

Please fill out the family history to the best of your ability. Check all that apply to biological family. Please list any relatives on either side of the family who have had the following:

OTHER FAMILY CONCERNS	RELATIONSHIP TO CHILD/ADOLESCENT	MOTHER'S SIDE	FATHER'S SIDE
MEDICAL			
Diabetes		☐	☐
Heart disease		☐	☐
Heart failure		☐	☐
"Immune" disease		☐	☐
Thyroid disease		☐	☐
Other neurological problems: _____		☐	☐
Other health problems: _____		☐	☐
PSYCHIATRIC/BEHAVIORAL HEALTH			
ADD/ADHD		☐	☐
Alcohol abuse/drinking problems		☐	☐
Anxiety		☐	☐
Bipolar disorder		☐	☐
Depression		☐	☐
Intellectual disability		☐	☐
Learning problems		☐	☐
Mania		☐	☐
OCD		☐	☐
Personality disorder		☐	☐
Psychiatric hospitalizations		☐	☐
Schizophrenia/other psychosis		☐	☐
Substance abuse/drug problems		☐	☐
Suicide attempts/killed themselves		☐	☐
Tics or movement disorders		☐	☐
COMMENT ON FAMILY PSYCHIATRIC/MEDICAL HISTORY:			

Child's Developmental History

PREGNANCY

How was the mother's overall health during the pregnancy with this child/adolescent? ☐ GOOD ☐ FAIR ☐ POOR ☐ UNKNOWN

During pregnancy, did the biological mother have any of the following? (select all that apply)

☐ BLEEDING ☐ INFECTION ☐ NO PRENATAL CARE ☐ OTHER PREGNANCY PROBLEMS/ILLNESS: _____

☐ GOT INJURED/HURT ☐ TOXEMIA ☐ UNKNOWN

During pregnancy, did the mother use any of the following? (select all that apply)

☐ ALCOHOL ☐ STREET DRUGS ☐ UNKNOWN

☐ TOBACCO ☐ PRESCRIPTION MEDICATIONS

IF YES, PLEASE EXPLAIN (describe amount and frequency, participation in treatment, birth defects of malformations due to drug/alcohol use among siblings):

BIRTH/EARLY INFANCY

Was this child/adolescent born before he/she was due (premature)? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, LENGTH OF PREGNANCY: _____ MONTHS

Was delivery? ☐ NORMAL ☐ BREACH ☐ CAESARIAN ☐ FORCEPS/VACUUM ASSISTED ☐ INDUCED ☐ UNKNOWN

Did the baby have any of the following during/after delivery? (select all that apply)

☐ BORN WITH CORD AROUND NECK ☐ HAD SEIZURES (FITS, CONVULSIONS) ☐ WAS A TWIN OR TRIPLET

☐ CAN'T REMEMBER

☐ INJURED DURING BIRTH ☐ TURNED BLUE (CYANOSIS) ☐ UNKNOWN

☐ HAD TROUBLE BREATHING ☐ NEEDED OXYGEN ☐ OTHER ISSUES/ COMPLICATIONS: _____

☐ HAD AN INFECTION ☐ SPENT TIME IN NICU

☐ WAS VERY JITTERY

Did the mother experience post-partum depression? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

CLIENT NAME/DOB/MRN (or affix label)

DEVELOPMENTAL MILESTONES

Have you or anyone else ever had concerns about this child/adolescent's development (i.e., walking, talking, learning)?

☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Are there any developmental milestones that the child/adolescent did late or is still having trouble with?

☐ SITTING	☐ SPOKE FIRST WORDS	☐ BOWEL TRAINED	☐ PLAYING COOPERATIVELY
☐ ROLLING OVER	☐ SAID PHRASES	☐ SLEEPING ALONE	☐ NO
☐ STANDING WITHOUT SUPPORT	☐ SAID SENTENCES	☐ DRESSING SELF	☐ UNKNOWN
☐ WALKING WITHOUT ASSISTANCE	☐ BLADDER TRAINED – DAY	☐ ENGAGING PEERS	☐ OTHER: _____
	☐ BLADDER TRAINED - NIGHT	☐ TOLERATING SEPARATION	_____

COMMENT ON DEVELOPMENTAL HISTORY/CONCERNS (describe further if needed):

Child's School Functioning/Education

Current school name (where enrolled):

Current grade level OR indicate highest grade completed (if not currently enrolled in school):

☐ NEVER ATTENDED OR BELOW PRESCHOOL	☐ KINDERGARTEN	☐ SOME COLLEGE
☐ NURSERY SCHOOL, PRE-SCHOOL, HEAD START	☐ GRADE: _____	☐ UNKNOWN
	☐ HIGH SCHOOL DIPLOMA OR GED	

Current education status (including home schooling):

☐ FULL-TIME (1st-12th grade: 20+ hours per week; kindergarten and >12 grade: 12+ hours per week).

☐ PART-TIME (1st-12th grade: less than 20 hours per week; kindergarten and >12 grade: less than 12 hours per week).

☐ NOT IN EDUCATIONAL OR TRAINING ACTIVITIES

☐ UNKNOWN

Concerns in any of the following areas (check all that apply):

☐ ATTENDANCE	☐ GRADES	☐ OTHER ACADEMIC/SCHOOL CONCERNS: _____
☐ DISCIPLINARY OR BEHAVIORAL ISSUES	☐ UNKNOWN	_____
	☐ N/A	

Has the child/adolescent ever skipped a grade or been held back? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Has the child/adolescent ever been suspended or expelled? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (date[s] and reason[s], # of times in current school year): _____

Does the child/adolescent have any diagnosed learning disabilities? (check all that apply)

☐ AUTISM SPECTRUM DISORDER	☐ SENSORY INTEGRATION DISORDER	☐ OTHER HEALTH IMPAIRED: _____
☐ DEVELOPMENTAL/COGNITIVE DELAY	☐ SPEECH OR LANGUAGE IMPAIRED	_____
☐ EMOTIONAL/BEHAVIORAL DISORDER	☐ TRAUMATIC BRAIN INJURY	☐ NO - child has been tested determined not to need services
☐ HEARING IMPAIRED	☐ VISUALLY IMPAIRED	☐ NO – never tested
☐ PHYSICALLY IMPAIRED	☐ UNKNOWN	

IF YES, PLEASE EXPLAIN: _____

Does the child/adolescent receive special education services? (check all that apply)

☐ INDIVIDUALIZED EDUCATION PLAN (IEP)	☐ OTHER: _____
☐ 504 PLAN	☐ NO
☐ SPECIAL EDUCATION ACCOMMODATIONS	☐ N/A

Please provide a copy of the IEP or 504 Plan (if applicable) if you haven't already done so.

COMMENTS ON CHILD/ADOLESCENT'S EDUCATION/SCHOOL FUNCTIONING (describe further if needed):

CLIENT NAME/DOB/MRN (or affix label)

Child's Living Situation & Family Relationships

LIVING SITUATION

Current type of housing (check all that apply):

☐ APARTMENT ☐ GROUP HOME ☐ HOUSE ☐ OTHER: _____
☐ CONDOMINIUM ☐ HOMELESS ☐ MOBILE HOME _____
☐ CORRECTIONAL FACILITY ☐ HOTEL/MOTEL ☐ SHELTER _____

Was the child/adolescent adopted or guardianshipped? ☐ YES ☐ NO ☐ UNKNOWN
IF YES, AT WHAT AGE? _____

Current custody and parenting plan:

☐ LIVES WITH BOTH PARENTS (biological or adoptive) IN SAME HOUSEHOLD
☐ SINGLE PARENT
☐ SHARED CUSTODY – parents in different households
☐ FOSTER CARE/YOUTH-IN-NEED-OF-CARE (YINC)
☐ OTHER (describe): _____

Please provide a copy of the parenting plan (if applicable) if you haven't already done so.

Was there ever a time when the child/adolescent could not live at home and someone else had to look after them?
☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

Is there a history of Child Protective Services (CPS) and/or Indian Child Welfare/beda?chelh involvement with family?
☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN (provide placement history, etc.): _____

Any family concerns or stressors?

☐ FAMILY MEMBER LEGAL ISSUES ☐ FAMILY MEMBER INCARCERATION ☐ TRANSPORTATION NEEDS ☐ UNKNOWN
☐ FINANCIAL CONCERNS ☐ LACK OF FOOD ☐ VIOLENCE/SAFETY ☐ OTHER FAMILY STRESSORS:
☐ FAMILY MEMBER DISABILITY ☐ HOUSING/UTILITIES ☐ NONE _____

Does the child/adolescent have immediate access to firearms at home, relative's home, and/or friend's home?
☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

Brief family history and major life events (important events, moves, accomplishments, losses/deaths, etc.):

What else do you think is important for us to understand about the housing/living situation?

CLIENT NAME/DOB/MRN (or affix label)

RELATIONSHIPS BETWEEN CHILD (CLIENT) AND PARENT/GUARDIAN - ***Please list below the names, ages, relationships, and other relevant information regarding the child/adolescent's parents/guardians/caregivers (i.e., biological parents, adoptive parents, step-parents, placement parents, etc.). Please indicate below the best descriptions of parent-child relationships.***

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	OCCUPATION	LIVING IN THE SAME HOME (AS CHILD)	QUALITY OF RELATION-SHIP	PARENT-CHILD CONFLICT
Biological Father				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
Biological Mother				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE

Cooperation between parents regarding child-rearing?

☐ ALWAYS ☐ USUALLY ☐ INCONSISTENTLY ☐ RARELY ☐ N/A

COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed):

RELATIONSHIPS(S) BETWEEN CHILD (CLIENT) AND SIBLING(S) - ***Please list the names and ages regarding the child/adolescent's siblings (i.e., biological siblings, step-siblings, placement siblings, etc.).***

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	LIVING IN THE SAME HOME (AS CHILD)	QUALITY OF RELATION-SHIP	SIBLING-CHILD CONFLICT
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE

COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed):

CLIENT NAME/DOB/MRN
(or affix label)

RELATIONSHIP(S) BETWEEN CHILD (CLIENT) AND OTHER PEOPLE LIVING IN THE HOME - *Please list below the names and ages regarding other individuals living in the same home as the child/adolescent (who weren't already listed in the tables above).*				
RELATIONSHIP TO CHILD/ADOLESCENT	**NAME**	**AGE**	**QUALITY OF RELATION-SHIP**	**INDIVIDUAL-CHILD CONFLICT**
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
COMMENT ON OTHER RELATIONSHIPS (describe further if needed):				

Child's Religious/Spiritual Involvement and Cultural Background

Does child/adolescent practice any particular cultural traditions, spirituality, and/or religion? ☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

Are there any personal, religious, spiritual or cultural practices or beliefs that you want taken into account when treatment planning? ☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

COMMENT ON RELIGIOUS/SPIRITUAL INVOLVEMENT AND CULTURE (describe further if needed):

Child's Gender Identity

Has the child given any signs that they identify with a gender that is not consistent with their biological sex?
☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

COMMENT ON GENDER IDENTITY (describe further if needed):

Child's Sexual Development (For Adolescents aged 12 to 18 years)

Have you ever had concerns about the adolescent's sexual development or behaviors? ☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

How does the adolescent identify their sexual orientation?

☐ STRAIGHT ☐ GAY ☐ LESBIAN OR GAY ☐ UNKNOWN
☐ BISEXUAL ☐ LESBIAN ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER: _____

Is the adolescent sexually active?

☐ YES ☐ NOT CURRENTLY ☐ NEVER ☐ UNKNOWN

Which birth-control/protection does the adolescent use? _____

COMMENT ON SEXUAL DEVELOPMENT (describe further if needed):

CLIENT NAME/DOB/MRN (or affix label)

Child's Employment History

Child/adolescent's current employment status (check all that apply):

☐ FULL TIME ☐ STUDENT – FULL TIME ☐ DISABLED ☐ NOT EMPLOYED
☐ PART TIME ☐ STUDENT – PART TIME ☐ SELF-EMPLOYED: _____ ☐ UNKNOWN

Any employment history for the child/adolescent? ☐ YES ☐ NO ☐ UNKNOWN
IF YES, PLEASE EXPLAIN: _____

COMMENT ON EMPLOYMENT HISTORY (describe further if needed):

Child's Legal Involvement/History

Is the child/adolescent under department of corrections (JRA/DOC) supervision? ☐ YES ☐ NO ☐ UNKNOWN

Is the child/adolescent under criminal court ordered mental health or substance use disorder treatment?
☐ YES ☐ NO ☐ UNKNOWN

If you answered yes to either of the above questions, is there a court order exempting child/adolescent from reporting requirements?
☐ NO ☐ YES - ***If so, a copy of the court order must be included in the record – please provide a copy.***

Does the child/adolescent have a history of legal involvement? (check all that apply)

☐ LEGAL CHARGES (i.e., traffic, civil, DWI/DUI, criminal, etc.)
☐ LEGAL CONVICTIONS (i.e., traffic, DWI/DUI, etc.)
☐ LESS RESTRICTIVE ALTERNATIVE (LRA) OR CONDITIONAL RELEASE (CR)
☐ SERVED ANY TIME IN DETENTION
☐ NO LEGAL INVOLVEMENT/NONE
☐ UNKNOWN
☐ OTHER: _____

COMMENT ON LEGAL INVOLVEMENT (describe further if needed):

Child's Social, Community, Recreational Activities and Supports

Who does and/or can the child/adolescent count on for support (i.e., important friends, extended family members, neighbors, coaches, school staff, church/faith community, etc.)? _____

Does the child/adolescent utilize any community resources/services?

☐ 12-STEP PROGRAM(S) (i.e., Alateen, etc.)
☐ BOYS & GIRLS CLUB
☐ CHILD ADVOCACY CENTER (CAC)
☐ FAMILY HAVEN
☐ MENTORING
☐ TUTORING
☐ SELF-HELP GROUPS
☐ SCHOOL-BASED SERVICES
☐ YOUTH SERVICES
☐ NO
☐ UNKNOWN
☐ OTHER SOCIAL SERVICES/ RESOURCES: _____

Does the child/adolescent have any hobbies, or is involved in any activities? (check all that apply)

☐ AFTER-SCHOOL ACTIVITIES
☐ CLUBS
☐ CHURCH/RELIGIOUS SERVICE
☐ PERFORMING ARTS
☐ SPORTS
☐ VOLUNTEERING
☐ NO
☐ UNKNOWN
☐ OTHER HOBBIES/ACTIVITIES: _____

COMMENT ON ACTIVITIES AND SUPPORTS (describe further if needed):

Additional Information

What else would you like for us to be aware of?

CLIENT NAME/DOB/MRN (or affix label)