Southeast Kansas Mental Health Center

CHILD & ADOLESCENT INTAKE ASSESSMENT[1]

This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.

Clinician Use Only: *ID:* _____ _____ *Date:* _____
Time In/Out: _____ *Units:* ____ ____
Intake Assessment, Code ☐ *ADMN (New) or* ☐ *ADMR (Reopen)*

IDENTIFYING INFORMATION

Client Name: _____ DOB:_____ Age:_____

☐ Male ☐ Female Height:_____ Weight:_____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

_____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

_____

School Status: _____ Cultural Identity: _____

Living with Whom?_____ How long in area? _____

Type of Residence:_____ Who referred you?

☐ self ☐ friend
☐ family member ☐ law enforcement
☐ mental health professional ☐ physician/nurse
☐ ad in phone book ☐ minister
☐ agency ☐ co-worker
☐ Other_____

PARENT INFORMATION

Your Name: _____ Age:_____

Other parent in residence Name: _____ Age:_____

How long have you been the primary caretaker? _____

Do you share joint custody? ☐ yes ☐ no If yes, how long? _____
If divorced, does the other custodial parent agree services should be sought? ☐ yes ☐ no ☐ don't know
Will both parents in residence be involved in treatment? ☐ yes ☐ no ☐ don't know
Will both biological parents be involved in treatment? ☐ yes ☐ no ☐ don't know

[1]Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

If divorced, other Biological Parent's Name: _____ Age:_____

Address: _____ City/State/Zip:_____

Home Phone: _____ Work Phone: _____ Message Phone: _____

If there is joint custody, list any recent problems _____

PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason for seeking help today? _____

_____

How would you rate the severity of this problem? ☐ moderate ☐ significant ☐ extrene

How long this been a problem? _____

How often does the problem occur? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ less often

Has there been:
Suicide thinking or attempts ☐ In the last month? ☐ Today ☐ _____

Thoughts of harming others or attempts ☐ In the last month? ☐ Today ☐ _____

How difficult was it to get your child or adolescent to come for help? _____

In what ways have the problems troubled you? _____

_____

Is there a court order to receive treatment? ☐ yes ☐ no

On the next page are some common problem areas for children/adolescents. To help focus on the most important issues, please complete the following checklist.

1) ☑ Check only **Problem Areas** with moderate or greater distress.
2) For each checked, also check the level of **Distress**, how long this has been a problem (**Duration**) and how often problem **Occurs**.

	PROBLEM AREAS	DISTRESS			DURATION					OCCURS				
		Moderate	Significant	Extreme	Less than 6 months	6	12	24	over 24	Constantly	Daily	Weekly	Monthly	Less often
☐	Academic Underachievement	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Adoption/Foster Care Issues	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Anger Management / Temper	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Antisocial Behavior / Legal System	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Anxiety or Panic	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Attachment Issues	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Attention/Concentration Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Bedwetting/Soiling/Toileting	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Blended Family Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Bullying or Intimidating Others	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Childhood Trauma	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Chronic Pain/Physical Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Conduct Disorder/Delinquency	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Dependency/Separation Anxiety	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Depression	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Disruptive/Attention Seeking	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Divorce Adjustment	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Eating Disorder	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Family Conflict	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Fire Setting	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Impulse Control	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Losing Touch With Reality	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Low Self-Esteem	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Lying or Manipulative	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Obsessive and/or Compulsive	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Oppositional/Defiant/"doesn't mind"	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Paranoid/Suspicious	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Peer/Sibling Conflict	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Phobias/Fears	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Physical Abuse	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Relationship Conflicts	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	School Related Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Sexual Abuse	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Sexual Confusion or Behavior	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Sleep Disturbance	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Social Discomfort	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Social Skills Deficits	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Speech/Language Difficulties	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Spiritual Confusion	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Substance Abuse/Dependence	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Suicidal Thoughts/Attempts	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Unresolved Grief/Loss	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐

What do you hope to get from treatment?_____

_____

What do you expect from your treatment team? _____

_____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in treatment? _____

_____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

_____

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

_____

_____

_____

_____

_____

_____

CHILD/ADOLESCENT STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **two (2)** resources **(strengths)** of your child or adolescent that will help in treatment?

- ☐ Family Support
- ☐ School
- ☐ Intelligence
- ☐ Network of Friends
- ☐ Stable Finances
- ☐ Good Health
- ☐ Spiritual
- ☐ Available Transportation
- ☐ Other: _____

Your child or adolescent possesses many different **abilities** that can be utilized to help overcome problems. What are **four (4)** of abilities that may be most useful in treatment? He or she can . . .

- ☐ take medication
- ☐ work cooperatively with others
- ☐ request help from others
- ☐ use self-help materials
- ☐ follow directions
- ☐ maintain consistent behavior
- ☐ be assertive
- ☐ provide leadership
- ☐ resolve conflicts
- ☐ keep appointments
- ☐ complete tasks assigned
- ☐ other: _____
- ☐ express thoughts and feelings
- ☐ abstain from alcohol/drugs
- ☐ analyze problems
- ☐ develop solutions to problems
- ☐ manage time effectively
- ☐ other: _____

FAMILY AND SIGNIFICANT RELATIONSHIPS

Child / Adolescent raised by? ☐ parents ☐ grandparent(s) ☐ single parent ☐ Other _____

What do you think about how your child was raised?_____

_____

What kind of relationship do you have today with your child? _____

How many brothers or sisters does you child have? _____

What kind of relationship does your child have with his or her brothers and sisters?_____

_____

Parent Marital Status?

☐never married ☐married ☐divorced ☐separated ☐widow(er) ☐living as married

How many times have you been married?_____ How long each time?_____

_____

Total number of children: ___his ___hers ___ours. If children live with you, please give:

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

What problems exist in your current intimate relationship? _____

_____

How much stress do you feel from parenting? ☐ None ☐ Some ☐ A lot ☐ Overwhelmed

How many close friends do you have? _____ How well do you get along with others? _____

To what organizations, clubs or teams do you belong? _____

_____

What problem(s) have you, your spouse and other children had? What about extended family?

Problems with	Father	Father's Mother	Father's Father	Father's Brother(s)	Father's Sister(s)	Father's Uncle(s)	Father's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Problems with	Mother	Mother's Mother	Mother's Father	Mother's Brother(s)	Mother's Sister(s)	Mother's Uncle(s)	Mother's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Child's or Adolescent's Brothers and Sisters -- WRITE IN *FIRST NAME(s)* IF A PROBLEM

Problems with	**Brother(s) First Name(s)**	**Sister(s) First Name(s)**
Aggressiveness, defiance behavior as a child		
Attention, overly active, and/or poor impulse control as a child		
Learning disability		
Dropped out of school		
Mental Retardation		
Psychosis or schizophrenia		
Depression lasting more than two (2) weeks		
Anxiety disorder than impaired school work		
Tics or Trourette's Disorders		
Alcohol and/or Drug Abuse		
Law Enforcement		
Physical Abuse		
Sexual Abuse		

DAILY ACTIVITY STRENGHTS AND LIMITATIONS

CHILD / ADOLESCENT DAILY ACTIVITIES[1]		**Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank**
1. Personal Care	Helps or manages general cleanliness: daily bath, shower, brush teeth	
2. Grooming	Assists or manages general appearance: hair, shave, comply with school rule	
3. Dress	Assists or responsibly cares for clean clothes, comply with school dress code	
4. Household Stability	Contributes to stability in the home (age-wise): respects others & property, shares in chores, involves caretakers in school-related projects, grades	
5. Physical & Mental Health	Assists or manages adequate weight, moods, outdoor exercise, aches; takes medications or over-the-counter drugs only with adult supervision.	
6.Communicate	Greets adults; listens, expresses feelings, anger, opinions effectively.	
7. Safety within environment	Plays it safe? Avoids guns, knives, matches, dangerous people or places where there likely is trouble or abuse; if driving, has safe record.	
8. Managing Time	Assists or manages time for promptly, regularly attending school & work (age-appropriate); completes tasks, sleeps, wakes up, eats on regular basis?	
9. Managing Money	Reliably handles or manages monetary allowance: abstains from overspending personal limits, betting, stealing, and borrowing?	
10. Nutrition	Eats at least 2 basically nutritious meals with caretakers; eats healthy snacks.	
11. Problem Solving	Understands presenting problems, reasons for seeking services; focuses on possible solutions for age-appropriate time periods; assists or manages difficult situations	
12. Family Relationships	Feels close to at least one other person at home; gets along with family or caretakers, feels loved?	
13. Alcohol, Drug Use	Abstains from smoking cigarettes, drinking alcohol, doing drugs or inhalants of any kind; avoids high risk drinking situations & people who use drugs	
14. Leisure Entertainment	Enjoys 2 or more fun & relaxing activities: music, watching or playing sports, reading, computer-board games, cards, artistic hobbies, movies, TV?	
15. Community Resources	Uses community activities, resources: after-school sponsored tutoring, clubs, sports, Scouts, YM/YWCA, library, church, dance.	
16. Peers/Social	Makes, keeps same-age friends; avoids bullying, gangs, cults, antisocial groups	
17. Sexual Behavior	Behavior is sexually responsible with girls, boys (and age-appropriate)? Avoids sexual activities, infections, pregnancy?	
18. Work & Productivity	Feels good about performance at school, considers grades to be good, completes school projects without undue difficulty. Has vocational goals.	
19. Coping Skills	Accepts adult correction without undue arguing, temper outburst; tolerate frustration, copes with disappointments, retains self-worth.	
20. Behavior Norms	Controls threatening or physical expression of anger, violent behaviors--either to self or others or to property. Law-abiding and responsible with rules, car, etc.	

[2]Adapted from Daily Living Activities Scale, Willa Pressmanes, used with permission.

DISCIPLINE

What methods have been used to discipline the child or adolescent?	Successful	Unsuccessful
Verbal reprimands		
Time out (isolation)		
Removal of privileges		
Removal of toys or activities		
Rewards		
Physical punishment		
Spend time with		
Let them have their way		
Avoid conflict		

How often does your child or adolescent comply with your first command? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

How often does your child or adolescent eventually comply with your commands? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

How much agreement and consistency do you and your spouse show in discipline? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

SPIRITUAL BACKGROUND

Are you a member of a local religious group? ☐ yes ☐ no Which one? _____
How active are you? ☐ extremely ☐ very ☐ somewhat ☐ not at all
How important is your faith? ☐ extremely ☐ very ☐ somewhat ☐ not at all

How might your faith/spirituality help? _____
Is there any spiritually related information you would like to add?

DEVELOPMENTAL FACTORS

Mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor ☐ Don't know

Alcohol consumed during pregnancy? ☐ yes ☐ no If yes, how much? _____

Street Drugs consumed? ☐ yes ☐ no If yes, used _____

During pregnancy used Tranquillizers (Valium, Librium, Xanax)? ☐ Cigarettes? ☐ Diabetes medication?
☐ Coffee or caffeine drinks? ☐ Seizure Medication? ☐ Antibiotics? ☐ Sleeping Medication?
☐ Psychiatric Medication _____

Number of previous pregnancies? _____ This delivery was ☐Normal? ☐Early? ☐ Long Labor?
☐Eclampsia? ☐Problem of Toxemia? ☐Rh Incompatibility? ☐Unusual Stress? ☐Breech delivery?
☐Water broke more than 24 hours early? ☐Induced delivery? ☐Forceps? ☐Cesarean?
☐Birth Defects? _____

As an infant, child was ☐Normal? ☐Slow? ☐Advanced? ☐Other_____

_____

As a toddler, child was ☐Normal? ☐Slow? ☐Advanced? ☐Other_____

_____

☐Bladder training problems? If so, started at age _____ He or she _____

☐Bowel training problems? If so, started at age _____ He or she _____

☐Ear problems? If so, started at age _____ He or she _____

☐Sleep problems? If so, started at age _____ He or she _____

☐Eating problems? If so, started at age _____ He or she _____

☐Other pre-school problems?_____

MEDICAL HISTORY

How is your child's or adolescent's health? ☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor

He or she has been treated for ☐Hearing ☐Vision ☐Coordination ☐Speech ☐Breathing

☐ Chronic health problem(s): _____

Has your child or adolescent had any of the following illnesses?

Mumps	☐	Chicken Pox	☐
Measles	☐	Whooping Cough	☐
Scarlet Fever	☐	Pneumonia	☐
Encephalitis	☐	Ear Infections	☐
Seizures	☐	Lead Poisoning	☐
Allergies	☐	Frequent runny nose	☐
Frequent Colds	☐	Frequent sinus infection	☐

Other: _____

Has your child or adolescent had any of the following accidents?

Broken bones	☐	Severe lacerations	☐
Head injury	☐	Severe bruises	☐
Stomach pumped	☐	Eye injury	☐
Lost teeth	☐	Sutures	☐

Other: _____

Has your child or adolescent had any of the following?

Tonsillitis	☐	Adenoids	☐
Hernia	☐	Appendicitis	☐
Eye, ear, nose, & throat	☐	Digestive Disorder	☐
Urinary tract	☐	Foot, Leg or Arm Disorder	☐
Burns	☐	Diabetes	☐

Other: _____

Has your child or adolescent had any of the following symptoms in the past 60 days?

☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty
☐ Breathing Difficulty	☐ Pulse Irregularity	☐ Memory Problems	☐ Cramps	☐ Bedwetting
☐ Vomiting	☐ Vision Changes	☐ Seizures	☐ Vaginal Discharge	☐ Blood in Stool
☐ Muscle Weakness	☐ Shakiness	☐ Dizziness	☐ Nervousness	☐ Diarrhea
☐ Mole/Wart Changes	☐ Tremor	☐ Falling	☐ Sleep Problems	☐ Constipation
☐ Hair Change	☐ Nosebleeds	☐ Confusion	☐ Gait Unsteadiness	☐ Sweats (Night)
☐ Hearing Loss	☐ Chest Pain	☐ Panic Attacks	☐ Numbness	☐ Sweats (Other)
☐ Headaches	☐ Tingling in Arms & Legs	☐ Loss of Consciousness	☐ Rash	☐ Bleeding gums

SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Did your family or school provide sex education? ☐ yes ☐ no
Is there a problem with sexual behavior? ☐ yes ☐ no
Was child ever forced to have sexual contact? ☐ yes ☐ no When? _____
Has he or she contracted a sexually transmitted disease? ☐ yes ☐ no
Sexually active in any way? ☐ yes ☐ no
What other significant sexually oriented problems do you wish to discuss?

LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Has your child or adolescent had contact with law enforcement? ☐ yes ☐ no
Has you child or adolescent ever been arrested or taken to court? ☐ yes ☐ no
Has your child or adolescent ever been placed in a correctional institution? ☐ yes ☐ no
If yes, when? _____ How Long? _____ Where? _____

Current legal issues or problems? _____

MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if child or adolescent has never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

<u>Thank you</u> for taking the time to complete this background information.
Please place this in the envelope provided, put your name on the outside and seal to insure privacy.
<u>Bring to your appointment.</u>