CHILD & ADOLESCENT INTAKE ASSESSMENT[1]

IDENTIFYING INFORMATION

Client Name ____ Date of Birth ______________ Age ______________

☐ Male ☐ Female ☐ Other____________________________

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 your child? ______________________________

PARENT INFORMATION

Your Name: ____Age ______________

Other Parent/Guardian in Residence Name: ____Age ____________

Do you have joint custody: ☐ Yes ☐ No If yes, how long? ____

If divorced, does the other parent agree services should be sought? ☐ Yes ☐ No ☐ Do not Know

Other Parent Name: ____

FAMILY AND SIGNIGICANT RELATIONSHIPS

Child/Adolescent Raised by? ☐ Parents ☐ Grandparent(s) ☐ Single Parent ☐ Other: ____________________________

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

____

How many brothers or sisters does your child have? ____

What kind of relationship does your child have with their 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.

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

PRESENTING CHALLENGE

What is the MOST SIGNIFICANT challenge or reason for seeking help today? ____________________

How would you rate the severity of this challenge? ☐ Mild ☐ Moderate ☐ Significant ☐ Extreme

How long has this been a challenge? ____________________

How often does the challenge 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 challenges troubled you as the caretaker? ____________________

____

Is there a court order to receive treatment? ☐ Yes ☐ No

What **would you like** regarding your services at Southeast Kansas Mental Health Center? For example, is there a service or medical treatment that you do not want? ____________________

____

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

____

CHILD/ADOLESCENT STRENGTHS, ABILITIES, NEEDS, & PREFERENCES

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

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

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

☐ Take Medication ☐ Be Assertive ☐ Express Thoughts or Feelings
☐ Work cooperatively with Others ☐ Provide Leadership ☐ Abstain from Alcohol/Drugs
☐ Request Help from Others ☐ Resolve Conflicts ☐ Analyze Problems
☐ Use Self-Help Materials ☐ Keep Appointments ☐ Develop Solutions to Problems
☐ Follow Directions ☐ Complete Tasks Assigned ☐ Manage Time Effectively
☐Maintain Consistent Behavior ☐ Other: ____________ ☐ Other: ____________

Challenges with:	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother
Aggressiveness, and 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						

DISCIPLINE

What methods have been used to discipline the child or adolescent?		
Verbal reprimands	Successful	Unsuccessful
Time out (isolations)		
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 <u>eventually</u> comply with your commands?
☐ Always ☐ Never ☐ More than half the time ☐ Less than half the time

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

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 your 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? __________ For how long? __________ Where? ______________________________

Current legal issues or problems? ______________________________

DAILY ACTIVITY STRENGTHS AND LIMITATIONS

CHILD/ADOLESCENT ACTIVITES[1]	**Mark the Following (S) for Strength or (L) for 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 rules	
3. Dress	Assists or responsibly cares for clean clothes, comply with school dress code	
4. Household Stability	Contributes to stability in the home (age-appropriate): 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 nutrition meals with caretakers; eats healthy snacks	
11. Problem Solving	Understandings 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 fund & 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, and 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]Adopted from Daily Living Activities Scale, Willa Pressmanes, used with permission.

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

Have you (child) been impacted by a traumatic event or experience? ☐ Yes ☐ No If yes, when? ______________________

Have you (child) ever been forced to have sexual contact? ☐ Yes ☐ No If yes, when? ______________________________

Have you (child) participated in High-Risk behavior (i.e., multiple sexual partners, or a partner with multiple sexual partners, shared needles)? ☐ Yes ☐ No

Would you like to share more about your trauma history that you may wish to discuss? _______________________________

____

DEVELOPMENTAL FACTORS

Mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor ☐ Do Not Know

Alcohol consumed during pregnancy? ☐ Yes ☐ No If yes, how much? ____

Street Drugs consumed during pregnancy? ☐ Yes ☐ No If yes, used? ____

During pregnancy used: ☐ Tranquillizers (Valium, Librium, Xanax) ☐ Cigarettes ☐ Diabetes Medication
☐ Coffee or Caffeine Drinks ☐ Seizure Medications ☐ Antibiotics ☐ Sleeping Medication
☐ Psychiatric Medication ____

Number of previous pregnancies _____

This delivery was ☐ Normal ☐ Early ☐ Long Labor ☐ Eclampsia ☐ Problems 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 ☐ Yes ☐ No If yes, started at age _____ They ____

Bowel Training Problems ☐ Yes ☐ No If yes, started at age _____ They ____

Ear Problems ☐ Yes ☐ No If yes, started at age _____ They ____

Sleep Problems ☐ Yes ☐ No If yes, started at age _____ They ____

Eating Problems ☐ Yes ☐ No If yes, started at age _____ They ____

Other Pre-School Problems ____

SPIRITUAL BACKGROUND

Is spirituality or religion important to you? ☐ Yes ☐ No Comments: ____________________

How important is your faith? ☐ Extremely ☐ Very ☐ Somewhat ☐ Not at All

What challenges have you had regarding spiritual issues?____________________

How might our faith/spirituality help you overcome your challenges? ____________________

MEDICAL HISTORY

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

The child or adolescent has been treated for ☐ Hearing ☐ Vision ☐ Coordination ☐ Speech ☐ Breathing

Chronic Health Problem(s) ____________________

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

☐ Broken Bone ☐ Severe Lacerations ☐ Stomach Pumped ☐ Head Injury ☐ Severe Bruises
☐ Eye Injury ☐ Lost Teeth ☐ Sutures Other ____________________

Has your child or adolescent had any of the following symptoms in the past 60 days (check all that apply)?

☐ Ankle Swelling ☐ Pulse Irregularity ☐ Lightheadedness ☐ Sleep Problems ☐ Cramps
☐ Breathing Difficulty ☐ Nervousness ☐ Memory Problems ☐ Vomiting ☐ Seizures
☐ Vision Changes ☐ Gait Unsteadiness ☐ Muscle Weakness ☐ Shakiness ☐ Dizziness
☐ Numbness ☐ Coughing ☐ Tremor ☐ Falling ☐ Bedwetting
☐ Hair Change ☐ Nosebleeds ☐ Confusion ☐ Diarrhea ☐ Hearing Loss
☐ Chest Pain ☐ Panic Attacks ☐ Constipation ☐ Headaches ☐ Tingling in Limbs
☐ Loss of Consciousness ☐ Other ____________________

MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if you have never been in mental health treatment.

Mental Health Treatment (Outpatient or Inpatient History				
Treated By/Hospital Name	From: Date to Date		For What Problems?	Results of Treatment

Medications (Current and Past)					
Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

Thank you for taking the time to complete this background information. Please place this in the envelope provided, put your child's name on the outside, and seal it to insure privacy. Bring with you to your child's appointment.