DOWNTOWN COUNSELING CENTER
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www.DCCCarlisle.com

CHILD/ ADOLESCENT INTAKE INFORMATION FORM

Please complete this form as best as you can and submit/send to Main@DCCCarlisle.com prior to your intake appointment. You can also bring the completed form to the appointment. Please know this form is reviewed during the intake and if not complete prior to your scheduled intake appointment, the appointment will be delayed and may have to be rescheduled.

Part 1 – IDENTIFYING DATA

Child's Name:	Age:	Date of Birth:	Gender: Male: ☐ Female: ☐
Name of Person Completing Information *(Last, First, MI)*	Relationship to Child:	Today's Date	
Name of Legal Guardians(s) (If different from person completing information):			
Address:			
Home Phone:	Work Phone:		
Cell phone:	Email:		

Part 2 – PRESENTING PROBLEM

What is (are) your reason(s) for bringing the child/teen today?

How long has the child/teen been experiencing these problems?

Has the child/teen had difficulties like this before? ☐ Yes ☐ No *(If yes, please explain)*

Is the child/teen having any self-destructive or suicidal thoughts? ☐ Yes ☐ No *(If yes, please explain)*

Part 3 – PAST PSYCHIATRIC HISTORY

List any previous psychiatric or substance abuse evaluations, counseling or hospitalizations the child/teen has had:

Reason	Location	Dates	Diagnosis (if known)

List any previous psychiatric medication the child/teen has used:

Medication	Dates	Effectiveness	Side Effects	Reason for Discontinuation

Has the child/teen ever attempted suicide in the past? ☐ Yes ☐ No *(If yes, please explain)*

Part 4 – MEDICAL HISTORY

Name and Location of Health Care Provider/ Pediatrician:	Office Phone of Health Care Provider/ Pediatrician:

List all allergies and reactions to medications:

List all medications that the child/teen is currently taking (please continue in Part 18 if more space required:

Name of Drug	Amount taken (dose)	Name of Drug	Amount taken (dose)

List all current and past medical or physical problems, including hospitalizations and traumatic injuries:

Is the child/ teen currently experiencing severe pain, fever, dizziness, or lightheadedness? ☐ Yes ☐ No

List any over the counter medications	Herbal products	Supplements/Vitamins

Part 4A - PAIN ASSESSMENT

Is the child/teen currently experiencing any physical pain? ☐ Yes ☐ No *(If yes, please explain below)*

(If experiencing pain, please score your pain on a 10 point scale where 0 = no pain and 10 = worst pain imaginable)

Please score the child/teen pain level:

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 5 – SUBSTANCE USE ASSESSMENT

Has the child/teen used or abused any substances within the past year? ☐ Yes ☐ No

(If Yes, continue below; if No skip to Tobacco and Caffeine sections below then begin Part 6

In the past year, has the child/teen ever drunk alcohol or used drugs more than intended? ☐ Yes ☐ No

In the past year, has the child/teen wanted or needed to cut down on alcohol or drug use? ☐ Yes ☐ No

What, if any, recreational or illicit drugs or medications has the child/teen used recently or in the past?

Has the child/teen ever felt they needed to drink a lot more or use more drugs in order to get an effect, or that they could no longer get high on the amount they were using? ☐ N/A ☐ Yes ☐ No

AUDIT Screening Tool	0	1	2	3	4
Instructions: Please check the box that most applies to you.	**Never**	**Monthly or less**	**2-4 times monthly**	**2-3 times weekly**	**4 + times weekly**
1. How often does the child/teen have a drink containing alcohol?	☐	☐	☐	☐	☐
	1-2	**3-4**	**5-6**	**7-9**	**10+**
2. How many drinks containing alcohol does the child/teen have on a typical day when drinking?	☐	☐	☐	☐	☐
	Never	**Monthly or less**	**Monthly**	**Weekly**	**Daily or almost daily**
3. How often does the child/teen have six or more drinks on one occasion?	☐	☐	☐	☐	☐
4. How often during the last year has the child/teen found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐
5. How often during the last year has the child/teen failed to do what was normally expected because of drinking?	☐	☐	☐	☐	☐
6. How often during the last year has the child/teen needed a first drink in the morning to get going after a heavy drinking session?	☐	☐	☐	☐	☐
7. How often during the last year has the child/teen had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐
8. How often during the last year has the child/teen been unable to remember what happened the night before because of drinking?	☐	☐	☐	☐	☐
	Never		**Yes, but not in last year**		**Yes, during the last year**
9. Has the child/teen or someone else been injured as a result of the child/teen's drinking?	☐		☐		☐
10. Has anyone been concerned about the child/teen's drinking or suggested they should cut down	☐		☐		☐
Total AUDIT Score ←					

TOBACCO USE	**CAFFEINE USE**
Does the child/teen smoke or use tobacco products? ☐ Yes ☐ No *(If no please go to next section)*	How many caffeinated beverages does the child/teen consume per day on average? (If zero skip to Part 6)
What does the child/teen smoke or use? ☐ Cigarettes ☐ Vape ☐ Snuff ☐ Cigars ☐ Pipe	
How much does the child/teen use in a day?	Does the child/teen ever feel irritable, jumpy or nervous because of their caffeine use? ☐ Yes ☐ No
How long has the child/teen been using tobacco products?	
Does the child/teen wish to quit? ☐ Yes ☐ No	Does caffeine use impair their sleep? ☐ Yes ☐ No

Part 6 – FAMILY PSYCHIATRIC HISTORY

List any family members who have been diagnosed or treated for any mental health problems?

Relationship	Problem/Diagnosis	Hospitalized	Medications prescribed?
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Have there been any deaths or suicidal behavior in the family? ☐ Yes ☐ No *(If yes, please explain)*

PART 7 – PSYCHOSOCIAL / DEVELOPMENTAL HISTORY

Where was the child/teen born?	Who raised the child/teen? ☐ Both Parents ☐ Mother ☐ Father ☐ Other Family ☐ Foster Parent(s) ☐ Adoptive Parent(s) ☐ Other:

Were there any complications at birth? ☐ Yes ☐ No *(If yes, please explain below)*

How many siblings does the child/teen have and what number child are they?

What is it like in the child/teen's home? ☐ Loving ☐ Comfortable ☐ Supportive ☐ Chaotic ☐ Abusive ☐ Other:

What type(s) of discipline are used to manage the child/teen's misbehavior?

Does or did the child/teen have any developmental delays or problems? ☐ Yes ☐ No *(If yes, please explain below)*

How old was the child/teen when they began to walk?

How old was the child/teen when they began to say first understandable words?

How old was the child/teen when they were toilet trained during the day? At night:

Has the child/teen ever been physically, sexually or emotionally abused? : ☐ Yes ☐ No *(If yes, please explain)*

Part 8 - CURRENT FAMILY RELATIONSHIP ASSESSMENT

Parent's Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	If parents are married, how long have they been married?

If married, are parents currently having any stressors or problems in the marriage? ☐ Yes ☐ No ☐ N/A *(If yes, please explain)*

Has any parent been married previously? ☐ Yes ☐ No ☐ N/A *(If yes, please explain custody arrangement)*

Are there any concerns about spousal domestic violence or abuse? ☐ Yes ☐ No *(If yes, please explain)*

Have the parents or any of the child/teen's legal guardians ever been referred to any agency such as Child Protective Services? ☐ Yes ☐ No *(If yes, please explain)*

Please list all of the children that live with the child/teen: ☐ N/A (continue below, if needed)

Child's name	Child's age	Child's Gender	Biological or stepchild		Does this child currently reside with you?
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Does anyone else reside in the household?	☐ Yes ☐ No	*(If yes, please explain below)*
Are their any behavior health problems with any of the child/teens siblings?	☐ Yes ☐ No	

Part 9 – RISK ASSESSMENT

Are there any firearms in the child/teen's home?	☐ Yes ☐ No
Does the child/teen have a history of suicidal or self-destructive thoughts or behaviors?	☐ Yes ☐ No
Does the child/teen have a history of homicidal (harm to others) thoughts or behaviors?	☐ Yes ☐ No
Are there any other safety concerns at this time?	☐ Yes ☐ No

Part 10 - SOCIAL SUPPORT ASSESSMENT

Does the child/teen have someone to talk to when they have a problem?	☐ Yes ☐ No
Is there someone the child/teen would ask for help if needed it?	☐ Yes ☐ No
Is the child/teen geographically separated from family and friends?	☐ Yes ☐ No
Is the child/teen having trouble with relationships with family, friends or school mates?	☐ Yes ☐ No
Has the child/teen recently withdrawn from family, friends, or school mates?	☐ Yes ☐ No

Does the child/teen belong to any groups or organizations that are supportive and helpful? ☐ Yes ☐ No *(If yes, please explain)*

Part 11 – SPIRITUAL/ CULTURAL ASSESSMENT

What is the child/teen religious or spiritual affiliation?

How much is religion or spirituality a source of strength or comfort to the child/teen?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

How much is spiritual community a source of support to the child/teen?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

Does the child/teen have any religious, spiritual or cultural practices that the counselor needs to be aware of during treatment? ☐ Yes ☐ No *(If yes, please explain)*

Part 12 - EDUCATIONAL ASSESSMENT

What is the child/teen's current school grade?

Is the child/teen currently attending school? ☐ Yes ☐ No *(If No, please explain):*

What are the child/teens typical grades?

Are current grades different from past grades? ☐ Yes ☐ No *(If Yes, please explain):*

Did the child/teen repeat or skip any grades?	☐ Yes ☐ No	*(If Yes, please explain below)*
Does or did the child/teen attend special education or gifted classes?	☐ Yes ☐ No	
Does the child/teen have any learning disabilities?	☐ Yes ☐ No	
Does the child/teen have any disciplinary problems in school?	☐ Yes ☐ No	
If yes, have they ever suspended or expelled?	☐ Yes ☐ No	

PART 13 - LEGAL ASSESSMENT

Has the child/teen ever been arrested?	☐ Yes ☐ No	*(If yes, please explain below)*
Is the child/teen currently on probation or parole?	☐ Yes ☐ No	
Does the child/teen presently have any other legal problems ?	☐ Yes ☐ No	

Part 14 – SEXUAL ASSESSMENT

Is the child/teen experiencing any sexual concerns?	☐ Yes ☐ No	*(If yes, please explain below)*
Does the child/teen have any concerns about their sexual identity?	☐ Yes ☐ No	

Part 15 – LEISURE, RECREATIONAL AND VOCATIONAL ACTIVITIES

What does the child/teen like to do in their free time?

Is there anything that limits their ability or desire to participate in leisure and recreational activities?

Part 16 – NUTRITIONAL ASSESSMENT

Height	Weight	In the last month has the child/teen gained or lost weight without trying? ☐ Yes ☐ No *(If yes, please explain below)*

How many meals does the child/teen eat per day?

Has the child/teen ever had problems with: *(If checked, please explain)*

☐ Being overweight ☐ Being underweight ☐ Binge eating ☐ Compulsive overeating
☐ Vomiting ☐ Laxative Abuse ☐ Excessive dieting ☐ Diuretic (Water pill) Abuse
☐ Other eating disorders/problems

Part 17 - FINANCIAL ASSESSMENT

Does the child/teen's family currently have any financial problems? ☐ Yes ☐ No *(If yes, please explain below)*

Part 18 – PATIENT DISCLOSURE

Please use this space to tell us anything additional that you may feel is relevant or may be important for your provider to know.

Parent Signature and Date: _____

Please list any individuals that you consent to have contacted regarding the child/teen's care:

☐ Doctor (Name):	☐ Gather further information ☐ Release information ☐ Make recommendations
☐ Other Person/ Agency (Name):	☐ Gather further information ☐ Release information ☐ Make recommendations