Seacoast Youth Services

Engaging Youth • Strengthening Families • Building Communities

Child/Adolescent Intake Form

Name: ____ Date of Birth: ________________

Legal Name (if different): ____ Gender: ☐M ☐F

Address: ____

School________________________________Grade______________Special Education (coding)____________

Primary Care Physician

Current Physician:____

Physician Address: ____

Physician Phone Number :( )______________________ Date of Last Exam ________________________

Insurance Information

Primary Health Insurance Company:____

Policy Holder Name:____

Policy Holder DOB :_______________________ Policy Holder Social Security # : _______________________

Policy Holder ID #:______________________________ Group/ Policy #:_____________________________

Additional Health Insurance Company:____

Policy Holder Name:____

Policy Holder DOB :_______________________ Policy Holder Social Security # : _______________________

Policy Holder ID #:______________________________ Group/ Policy #:_____________________________

Type of Additional Coverage: ☐ Secondary ☐ EAP (Employee Assistance Program)

Client Authorization

I understand that I am fully responsible for any fees for professional services provided to me or to my dependents. My signature below authorizes Seacoast Youth Services to submit claim forms for me directly to my insurance company, but does not guarantee payment of claims. I authorize the release of any medical or other information required by my insurance company to receive authorization for services or to process claims for services to me to my dependents.

Signature ____ Date ________________________________

Contact Information

Parent/Guardian Information #1 Name: ____

Home Address____

Email____

Primary Contact Number: ____ ☐Home ☐Work ☐Cell

Alternative Contact Number: ____ ☐Home ☐Work ☐Cell

Occupation____ Employer___________________________________

Relationship Status: ☐single ☐committed ☐married ☐separated ☐divorced ☐widowed

Partner/Spouse name____

Past or present medical, psychological, or substance abuse problems of Parent/Guardian #1:

Parent/Guardian Information #2 Name: ____

Home Address____

Email____

Primary Contact Number: ____ ☐Home ☐Work ☐Cell

Alternative Contact Number: ____ ☐Home ☐Work ☐Cell

Occupation____ Employer___________________________________

Relationship Status: ☐single ☐committed ☐married ☐separated ☐divorced ☐widowed

Partner/Spouse name____

Past or present medical, psychological, or substance abuse problems of Parent/Guardian #2:

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Presenting Problems and Concerns

Describe the problem that brought you here today:

Checklist of Concerns:

Please mark all of the items below that apply and feel free to add any others at the bottom

☐ Affectionate
☐ Argues, “talks back,” smart-alecky, defiant
☐ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
☐ Cruel to animals
☐ Conflicts with parents over rule breaking, money, chores, homework, grades, choices in music/clothes/hair/ friends
☐ Cries easily, feelings are easily hurt
☐ Disobedient, uncooperative, refuses, noncompliant, doesn’t follow rules
☐ Distractible, inattentive, poor concentration, daydreams, slow to respond
☐ Drug or alcohol use
☐ Eating—refuses, appetite increase or decrease, odd combinations, overeats
☐ Failure in school
☐ Fearful
☐ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
☐ Fire setting
☐ Friendly, outgoing, social
☐ Gambling
☐ Independent
☐ Lacks respect for authority, insults, dares,

☐ Likes to be alone, withdraws, isolates
☐ Lying
☐ Low frustration tolerance, irritability
☐ Nightmares
☐ Obedient
☐ Obesity
☐ Overactive, restless, hyperactive, out-of-seat behaviors, restlessness, fidgety, noisiness
☐ Recent move, new school, loss of friends
☐ Relationships with brothers/sisters or friends/peers are poor—competition, fights, teasing/provoking, assaults
☐ Responsible
☐ Sad, unhappy
☐ Self-harming behaviors—biting or hitting self, head banging, scratching self
☐ Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors
☐ Suicide talk or attempt
☐ Temper tantrums, rages
☐ Thumb sucking, finger sucking, hair chewing
☐ Tics—involuntary rapid movements, noises, or word productions
☐ Teased, picked on, victimized, bullied
☐ Wetting or soiling the bed or clothes

provokes, manipulates	

Any other characteristics: ____

Please look back over the concerns you have checked off and choose the one that you most want your child/adolescent to be helped with and circle it.

Has your child/adolescent ever had thoughts, made statements, or attempted to hurt himself/herself?

☐ Yes ☐ No If yes, please describe: ____

Has your child/adolescent ever had thoughts, made statements, or attempted to hurt someone else?

☐ Yes ☐ No If yes, please describe: ____

Has your child/adolescent recently been physically hurt or threatened by someone else? ☐ Yes ☐ No

If yes, please describe: ____

Relationship	**Name**	**Lives with Child? (Y/N)**	**Age**	**Quality of Relationship**
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other Relatives				

Family Mental Health Problems	**Who ?**	**Family Mental Health Problems**	**Who ?**
Hyperactivity		Panic Attacks	
Sexually Abused		Obsessive-Compulsive	
Depression		Anger/Abusive	
Manic Depression		Schizophrenia	
Suicide		Eating Disorder	
Anxiety		Alcohol Abuse	
Drug Abuse		Other:	

☐ Parents legally married or living together

☐ Parents temporarily separated

☐ Parents divorced or permanently separated

☐ Mother Remarried: Number of times ________

☐ Father Remarried: Number of times ________

Please check if your child/adolescent has experienced any of the following types of trauma or loss:

☐ Emotional Abuse
☐ Physical Abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Loss of a loved one
☐ Financial Problems
☐ Sexual Abuse
☐ Homelessness
☐ Crime victim

Were there any medical problems during the pregnancy or birth of this child? ☐ Yes ☐ No

If yes, please describe: ____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child?

☐Yes ☐ No   If yes, please describe: ____

Were there any developmental delays in early childhood (crawling, walking, talking, toileting ect.)?

☐Yes ☐ No   If yes, please describe: ____

Previous Mental Health

Type of Treatment	When?	Provider/Program	Reason for Treatment
☐ Outpatient Counseling			
☐ Medication (Mental Health)			
☐ Psychiatric Hospitalization			
☐ Drug/Alcohol Treatment			
☐ Self-help/ Support Group			

School Information

This year's school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	Comments:
Past school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	Comments:
This year's school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	Comments:
Past school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	Comments:

Has your child/adolescent had any of the following difficulties at school?

☐ Suspension ☐ Detentions ☐ Incomplete homework ☐ Learning problems ☐ Poor grades

☐ Teased, picked on, bullied ☐ Speech problems ☐ Attendance problems ☐ Gang influence

Does your child have an after-school provider? ☐ Yes ☐ No   If so, who?_________________________________

Has your child/adolescent ever repeated or skipped a grade? ☐ Yes ☐ No

If yes, which one(s)? ____

Has your child/adolescent ever received Special Education services? ☐ Yes ☐ No

If yes, please describe services received:____

What does your child's/adolescent's teacher(s) say about him/her?_______________________________________

____

Substance Use History

Substance Type	Current Use (last 6months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Marijuana								
Alcohol								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamine								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Has your child/adolescent ever had withdrawal symptoms when trying to stop using any substances?

☐ Yes ☐ No If yes, please describe: ____

Has your child/adolescent ever had problems with school, work, relationships, health, the law, etc. due to substance use?

☐ Yes ☐ No If yes, please describe: ____

Medical Information

Has your child/adolescent ever experienced any of the following medical conditions during their lifetime?

☐ Allergies ☐ Asthma ☐ Seizures ☐ Vision problems

☐ Stomach aches
☐ Chronic pain
☐ Serious accident
☐ Dizziness/fainting
☐ Headaches
☐ Surgery
☐ Head injury
☐ Meningitis
☐ High fevers
☐ Sleep disorder
☐ Sexually transmitted disease
☐ Hearing problems
☐ Diabetes
☐ Miscarriage
☐ Abortion
☐ Other :_______________

Please list any current health concerns: ____

Current prescription medications: ☐Yes ☐No

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.):
____

Allergies and/or adverse reactions to medications: ☐Yes ☐No

If yes, please list: ____

Interpersonal/ Social/ Cultural Information

Please describe your child's/adolescent’s social support network (check all that apply):

☐ Family ☐ Friends ☐ Neighbors ☐ Students ☐ Community Group ☐ Co-workers

☐ Religious/Spiritual Center (which one) ______________________ ☐ Support/ Self-Help Groups

To which cultural or ethnic group does your child/adolescent belong? ______________________________________

How important are spiritual matters to your child/adolescent?

☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/ religious beliefs to be incorporated into your child's counseling? ☐ Yes ☐ No

Please describe your child's/adolescent’s strengths, skills, and talents:

Describe any special areas of interest or hobbies (art, books, physical fitness, ect.): __________________________