

MID-OHIO PSYCHOLOGICAL SERVICES, INC.
CLIENT SELF-REPORT PSYCHO-SOCIAL INTAKE
(Adolescent/Child Form)

Client Name _____ Date _____

Parent/Legal Guardian Name(s) _____

Gender _____ Date of Birth _____ Age _____

Race/Ethnic _____ County of Residence _____

Social Security Number _____ Phone # _____

Permanent Address _____

Where are you living currently _____

Emergency Contact _____ Phone # _____ Relationship _____

Address _____

Case Manager (Name/Agency) _____ Attorney _____

Legal Status: Probation Parole Pending Case None

Who sent you to this agency _____

FAMILY & SOCIAL INFORMATION

Name of biological parents _____

Who raised you _____

Names and ages of brother and sisters _____

Who do you live with currently _____

Who gives you emotional support _____

Who gives you financial support _____

Religious/Spiritual Involvement _____

Criminal History _____

EDUCATIONAL & OCCUPATIONAL HISTORY

Where do you go to school _____

Current Grade/Highest Level of Education _____

Are you in any special classes(explain) _____

What kind of grades do you get _____

Extracurricular Activities _____

What kind of jobs have you done _____

Other sources of income _____

ABUSE HISTORY

Have you ever been physically abused (describe) _____

Have you ever been sexually abused (describe) _____

Have you ever been mentally abused (describe) _____

Have you always had food and shelter (describe) _____

Have you ever witnessed domestic violence (describe) _____

History of Child Protective Services Involvement _____

Have you ever used the following	Please Check	How often do you use?	When did you last use?
Alcohol			
Marijuana (pot, weed, etc.)			
Cocaine (crack, rock, etc.)			
Depressants (Xanax, Ativan, Klonopin, downers)			
Amphetamines (uppers, meth, Ritalin, Adderall)			
Hallucinogens (LSD, acid, "shrooms," salvia)			
Opiates (heroin, morphine, Oxy, pain medication, suboxone)			
Inhalants (huffing, poppers, whip-its, dusters)			
K2, bath salts, spice			
Other Substances			
Tobacco			
Caffeine			

Are you sexually active: _____

MENTAL HEALTH HISTORY

Have you ever seen a counselor before (describe) _____

Have you ever been in a psychiatric hospital (describe) _____

Have you ever attempted suicide (describe) _____

Have you ever received treatment for a drug or alcohol problem _____

Why are you seeking counseling at the present time (Please give details) _____
