

**PSYCHO-SOCIAL INTAKE
(Adolescent/Child Form)**

Rev. 07/03/2008

THERAPIST _____ DATE _____

Client Name _____ Case # _____

Gender _____ Date of Birth _____ Age _____

Race/Ethnic _____ County of Residence _____

Social Security Number _____ Phone # _____

Permanent Address _____

Current Placement/Address _____

Legal Guardian _____ Relationship _____

Emergency Contact _____ Phone # _____ Relationship _____

Case Manager (Name/Agency) _____

Legal Status/Officer _____

Referral Source/Reason _____

Referral Issue (per client) _____

Referral Issue (per Family/Guardian) _____

FAMILY & SOCIAL INFORMATION

Family of Origin _____

Parents Occupations _____

Siblings _____

Current Living Condition/Household Composition and Quality of Relationships _____

Describe household composition, quality of relationships, and custody/parenting plan for Secondary Family Systems on back of page

Support System _____

Friends/Significant Others _____

Community Interests/Involvement _____

Religious/Spiritual Involvement _____

Legal System Involvement _____

Ethnicity Impact _____

EDUCATIONAL & OCCUPATIONAL HISTORY

School Name _____ Location _____

Current Grade/Highest Level of Education _____

Previous Grades/Retentions _____

Completion of Proficiency Tests _____

Special Classes/GPA _____

Behavioral Problems at School _____

Extracurricular/Hobbies _____

Occupation/Employment History _____

Other Sources of Income _____

VICTIMIZATION HISTORY

Abuse: Physical _____

Sexual _____

Mental _____

Neglect _____

C.P.S. Involvement/Worker _____

GAL or CASA Worker _____

POTENTIALLY ABUSIVE BEHAVIOR

Substance	Onset	Current	Highest	Most Recent	Tolerance/ Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphétamines					
Hallucinogens					
Opiates					
Inhalants					
Other					
Tobacco					
Caffeine					

Sexual Activity _____

Other (ie. Gambling, Food) _____

Parents/Family Use of AOD _____

MENTAL HEALTH AND AOD TREATMENT HISTORY

Counseling _____

Previous Diagnosis: _____

Previous Medications/Efficacy: _____

Hospitalizations _____

Bizarre Ideation History _____

Suicide/Homicide Behavior/Ideation _____

Previous #AOD Treatment Episodes: Outpatient _____ Residential _____ Rehab _____
Providers: _____

Current AOD Treatment: _____

Family MH/AOD History: _____

MEDICAL STATUS

Primary Physician (Name/Address) _____

Current Problems _____

Current Medications _____

Personal Medical History _____

Hospitalizations _____

History of Brain Trauma _____

Birth/Developmental Milestones: _____

Enuresis/Encopresis _____

Sleep Pattern _____ Onset Problems _____ Maintenance Problems _____

Eating Pattern _____

ADL Limitations: _____

Family Medical History _____

COGNITIVE/BEHAVIORAL FUNCTION

Height/Weight _____

Appearance _____

Grooming _____

Eye Contact/Presentation _____

Attitude: Open Responsive Guarded Defensive Malingering Varied

Speech: Appropriate Pressured Unusual Rate: _____ Unusual Rhythm: _____ Unusual Volume: _____

Oriented x3 _____

Recent Recall _____

General Fund of Knowledge: _____

Abstract Reasoning: Apple/Banana Coat/Suit Poem/Statue

Estimate of I.Q. _____

Affect: Manic Depressed Within Normal Limits Other

Mood: Varied Appropriate Depressed/Sad Euphoric Flat Constricted Other: _____

Anxiety: None Noted Situational Only Psychomotor Agitation Hypervigilance Other: _____

Thought Content:

 Bizarre Ideation _____

 Suicidal/Homicidal _____

Current Stressors/Coping Mechanisms: _____

Other Acute Risk Factors _____

[] Client strengths/assets, weaknesses/limitations, diagnostic impressions, and initial intervention goals can be found on the initial ISP/POA that has been generated as part of this diagnostic assessment.