## Screening Information

ACCT#: ____________________

Child/Adolescent

**Please Print Clearly:**

Date: _____________ Readmit: ____ Yes ____ No

Last Name: __________________________ First Name: ________________________ Middle Initial: ________________

Address: ____________________________ City: _________________ State: ________ Zip Code: ____________________

Telephone: Home ________________________ Work _________________________ Cell ____________________________

Ok to leave messages? Home: ____ Yes ____ No Work: ____ Yes ____ No Cell: ____ Yes ____ No

Birthdate: _______________________ Age: ________ Gender: ____ F ____ M Race: _______________________

Name of Parent/Guardian_________________________________________________ Phone: _______________________

Address________________________________________ City_______________ State________ Zip Code_____________

Would you like to receive a monthly newsletter? Yes please, my email is ________________________________ No thank you ___

**Referral Source**

How did you hear about Lillybrook Counseling Services (or from whom)? __________________________________________

Address: __________________________________________ City: ______________ State: ______ Zip: ____________

Phone: ___________________________________________

**Emergency Information**

In case of emergency, contact:

1. Name: _________________________ Relationship: _____________________ Phone: _______________________

Address: _________________________ City: ____________________________ State: _______ Zip: ___________

2. Name: _________________________ Relationship: _____________________ Phone: _______________________

Address: _________________________ City: ____________________________ State: _______ Zip: ___________

Physician: ______________________________________________________________ Phone: _______________________

Address: _________________________ City: ____________________________ State: _______ Zip: ___________

**Employment Information**

Client/Guardian: Place: ____________________________________ Occupation: ___________________________________

Spouse: Place: ___________________________________________ Occupation: ___________________________________

**Insurance Information**

Primary Insurance: __________________________________ Secondary Insurance: ___________________________________

Contract/ID#: ______________________________________ Contract/ID#: __________________________________________

Group/Acct#: ______________________________________ Group/Acct#: __________________________________________

Subscriber: ________________________________________ Subscriber: ___________________________________________

Subscriber Date of Birth: ____________________________ Subscriber Date of Birth: ______________________________

Client's relationship to subscriber: _____________________ Client's relationship to subscriber: ________________________

**If you need any more space for any of the questions, please use the back of the sheet.**

**Primary reason(s) for seeking services:**

| | | | | |
|---|---|---|---|---|
| ___ Anger Management | ___Anxiety | ___Coping | ___Depression | ___Eating Disorder |
| ___Fear/Phobias | ___Mental Confusion | ___Sexual Concerns | ___Sleeping Problems | ___Addictive Behaviors |
| ___Alcohol/Drugs | ___Past Trauma | ___Hyperactivity | ___Self-injury | ___Self-esteem |
| ___Impulsivity | ___Behavior Problems | ___ Distractibility | ___Other (please specify): ____________________ | |

________________________________________________________________________________

________________________________________________________________________________

How long have these symptoms been present? ____________________________________________

What are you goals for your child's therapy? (What outcome(s) would you like to take place?) ______________________

________________________________________________________________________________

Any additional information that would assist us in understanding your concerns or problems______________________

________________________________________________________________________________

What family involvement would you like to see in therapy?______________________________________

________________________________________________________________________________

**Behavioral/Emotional**

___Affectionate
___Aggressive (__Verbal __Physical)
___Alcohol dependence
___Angry
___Anxiety
___Attachment to dolls
___Avoiding adults
___ Bedwetting
___Blinking/Jerking
___Bizarre behavior
___Bullies threatens
___Careless, reckless
___Chest pain
___Clumsy
___Confident
___Cooperative
___Computer addiction
___Defiant
___Depression
___Destructive
___Difficulty speaking
___Dizziness
___Drug dependence
___Eating disorder
___Enthusiastic
___Excessive masturbation
___Expects Failure
___Fatigue
___Fearful
___Frequent injuries
___Frustrated easily
___Gambling
___Generous
___Hallucinations
___Head banging
___Heart problems
___Hopelessness
___Hurts animals
___Imaginary friends
___Impulsive
___Irritable
___Lazy
___Learning problems
___Lies frequently
___Listens to reason
___Loner
___Low self-esteem
___Messy
___Moody
___Nightmares
___Obedient
___Often sick
___Oppositional
___Overactive
___Overweight
___Panic attacks
___Phobias
___Poor appetite
___Psychiatric problems
___Quarrels
___Sad
___Selfish
___Separation anxiety
___Sets fires
___Sexual addiction
___Sexual acting out
___Shares
___Short attention span
___Shy, timid
___Sleeping problems
___Slow moving
___Soiling
___Speech problems
___Steals
___Stomach aches
___Suicidal threats
___Suicidal attempts
___Talks back
___Teeth grinding
___Thumb sucking
___Tics or twitching
___Unsafe behaviors
___Unusual thinking
___Weight loss
___Withdrawn
___Worries excessively
___Sleeping in bed problems
___Other: ________________________________________________

**What areas of your life are being affected by the above?**

**Social**

__Unable to form or maintain friendships
__Withdrawal from family and friends
(excessive desire to be alone)
__Increased conflict with others
__Loss of interest in social activities
__Phobia
__Poor social skills
__Attachment problems

**Occupational**

__Unable to maintain job
__Absenteeism
__Conflicts with co-workers
__Tardiness
__Reduced productivity
__Disciplinary action for poor performance

**Academic**

__Failing grades
__Skipping school
__Tardiness
__Detention
__Reduced productivity
__Homework problems
__Fighting/conflicts with students/teachers

**Physical**

__Decreased energy/fatigue
__Difficulty getting out of bed or insomnia
__Decreased/Increased appetite (circle one)
__Substantial weight loss or gain (circle one)
__Psychosomatic complaints (headaches, stomach aces, etc.)
__Frequent illness
__Bed wetting

**Affective Distress**

__Crying spells
__Mood swings
__Concentration problems
__Disorganized thoughts
__Feeling overwhelmed with emotions
__Worrying that interferes with the ability to concentrate
__Memory problems
__Anger/rage

**Risk Assessment**

__ Suicidality
__ Homicidality
__ Drug/Alcohol use
__ Unprotected sex
__ Cutting/Self-injury

Please describe how the above symptoms impair your ability to function effectively (e.g. socially, occupationally, academically, emotionally, physically) ____________________________________________________________

____________________________________________________________

____________________________________________________________

**Do you feel suicidal/homicidal at this time?** ___ No ___ Yes
**If Yes, explain**: ____________________________________________________________
**Are you engaged in any risk-taking behaviors?** ___ No ___ Yes
**If Yes, explain:** ____________________________________________________________

Has the child/adolescent experienced death? (friends, family, pets, other) __No __Yes

At what age? ___ If yes, describe the child's/adolescent's reaction____________________________________________

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.) __No __Yes

If yes, describe____________________________________________________________

Do you suspect your child is using any alcohol or drugs? (including illicit, prescription, over-the-counter or cigarettes) __No __Yes

Explain____________________________________________________________

How are behaviors generally handled?____________________________________________________________

____________________________________________________________

**Counseling/Prior Treatment History**

| | Yes | No | When | Where | Overall Experience |
|---|---|---|---|---|---|
| Mental health counseling | ___ | ___ | __________ | ____________________ | ____________________________ |
| | ___ | ___ | __________ | ____________________ | ____________________________ |
| | ___ | ___ | __________ | ____________________ | ____________________________ |
| Psychiatrist for medication | ___ | ___ | __________ | ____________________ | ____________________________ |
| | ___ | ___ | __________ | ____________________ | ____________________________ |
| Suicidal/homicidal thoughts | ___ | ___ | __________ | ____________________ | ____________________________ |
| Suicidal/homicidal attempts | ___ | ___ | __________ | ____________________ | ____________________________ |
| Drug/Alcohol Treatment | ___ | ___ | __________ | ____________________ | ____________________________ |
| Mental Health Hospitalizations | ___ | ___ | __________ | ____________________ | ____________________________ |
| Involvement with self-help groups (e.g. AA, Al-Anon, NA) | ___ | ___ | __________ | ____________________ | ____________________________ |

Previous mental health diagnosis: ____________________________________________________________
Any immediate family in treatment currently? If yes, whom and where? ________________________________
________________________________________________________________________________

**Parental Information**

**Client's Mother**
Name________________________________ Age______ Occupation____________________ FT___ PT___
Where employed___________________________________________ Work phone______________________________
Mother's education______________________________________________________________________
Is the child currently living with the mother? __No __Yes If no, which of the following:
__Step-parent __Adoptive parent __Foster Home __ Other____________________________________
Is there anything notable, unusual or stressful about the child's relationship with the mother? __No __Yes If yes, describe:
________________________________________________________________________________
________________________________________________________________________________
How is the child disciplined by the mother (e.g. grounding, spanking)?_____________________________
For what reasons is the child disciplined by the mother?_______________________________________

**Client's Father**
Name________________________________ Age______ Occupation____________________ FT___ PT___
Where employed___________________________________________ Work phone______________________________
Father's education______________________________________________________________________
Is the child currently living with the father? __No __Yes If no, which of the following:
__Step-parent __Adoptive parent __Foster Home __ Other____________________________________
Is there anything notable, unusual or stressful about the child's relationship with the father? __No __Yes If yes, describe:
________________________________________________________________________________
________________________________________________________________________________
How is the child disciplined by the father (e.g. grounding, spanking)?_____________________________
For what reasons is the child disciplined by the father?_______________________________________

With whom does the child live at this time?______________________________________________
Were the child's parents ever married? __No __Yes
Are parents divorced or separated? __No __Yes
If yes, who has legal/physical custody?___________________________________________________
****BRING CUSTODY PAPERWORK TO FIRST SESSION IF PARENTS ARE DIVORCED****
Amount of time spent with each parent____________________________________________________

Who handles responsibility for your child in the following areas?

School __Mother __Father __Shared __Other (specify)________________________________

Health __Mother __Father __Shared __Other (specify)________________________________

Problem behavior __Mother __Father __Shared __Other (specify)________________________________

Discipline Techniques:____________________________________________________________

Quality of Parents' Marriage: __Good __ Average __Poor

Does arguing happen in front of the child? __No __Yes

Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial to know for counseling? __No __Yes If yes, describe________________________________________________

________________________________________________________________________________

**Client's Siblings and Others Who Live in the Household**

| Names of Siblings | Age | Gender | Lives | | Quality of relationship with the client | | |
|---|---|---|---|---|---|---|---|
| | | | __Home | __Away | __Poor | __Average | __Good |
| | | | __Home | __Away | __Poor | __Average | __Good |
| | | | __Home | __Away | __Poor | __Average | __Good |

| Others living in the household | Age | Gender | Relationship (e.g. cousin, foster child) | Quality of relationship with the client | | |
|---|---|---|---|---|---|---|
| | | | | __Poor | __Average | __Good |
| | | | | __Poor | __Average | __Good |
| | | | | __Poor | __Average | __Good |

Comments__________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Childhood/Adolescent History**

**Pregnancy/Birth**

Has the child's mother had any occurrences of miscarriages or stillborns? __No __Yes If yes, describe________________________

________________________________________________________________________________

Was the pregnancy with child planned? __No __Yes Length of pregnancy__________________________

Mother's age at child's birth_____ Father's age at child's birth _____ Child # ____ of ____ total children.

While pregnant did mother smoke? _________ If yes, what amount______________________________

Did the mother use drugs or alcohol? ________ If yes, type/what amount___________________________

While pregnant, did the mother have any medial or emotional difficulties (e.g. surgery, hypertension, medication) __No __Yes

If yes, describe__________________________________________________________________

Length of labor ______________ Induced __No __Yes Caesarean __No __Yes

Baby's birth weight______ Baby's birth length________________

Describe any physical or emotional complications with the delivery_______________________________

________________________________________________________________________________

Describe any complications for the mother or the baby after the birth_____________________________

________________________________________________________________________________

Length of hospitalization: Mother_____________________ Baby_________________________

**Infancy/Toddlerhood** Check all that apply

| | | | |
|---|---|---|---|
| __Breast fed | __Milk allergies | __Vomiting | __Diarrhea |
| __Bottle fed | __Rashes | __Colic | __Constipation |
| __Not cuddly | __Cried often | __Rarely cried | __Overactive |
| __Resisted solid food | __Trouble sleeping | __Irritable when awakened | __Lethargic |

**Developmental History** Please note the age at which of the follow behaviors took place to the best of your ability. Where the age is unknown, please indicate, on time, early, or late.

Sat alone ______________________________ Dressed self ________________________________
Took 1st steps___________________________ Tied shoelaces ______________________________
Spoke words____________________________ Rode two-wheeled bike ______________________
Spoke sentences_________________________ Toilet trained_______________________________
Weaned________________________________ Dry during day______________________________
Fed self________________________________ Dry during night_____________________________
Began puberty___________________________ Menstruation________________________________
Voice change____________________________ Breast development__________________________
Compared with other family members, child's development was: __slow __average __fast

Age for issues or injuries
Convulsions______________________________ Injuries_____________________________________
Hospitalizations__________________________ Other_______________________________________
Issues that affected child's development (e.g. physical/sexual abuse, inadequate nutrition, neglect):______________________________
_____________________________________________________________________________________________________

Any history of being abused by others? __ No __ Yes
__ Experienced: __ Witnessed: __ Neglect __ Abuse (__ Emotional __ Physical __ Verbal __ Sexual)
__ Violence __ Sexual assault
Explain: _____________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
What age was the child when her or she was abused?__________________________________________
Any history of child abusing others? __No __Yes If yes, describe______________________________________________
_____________________________________________________________________________________________________
Is there a history of any important separations, losses, deaths, traumas?_________________________________________
_____________________________________________________________________________________________________

**Immunization record** (Check immunizations the child/adolescent has received.)

| | **DPT** | **Polio** | | |
|---|---|---|---|---|
| 2 months | | | 15 months | __MMR |
| 4 months | | | 24 months | __HBPV |
| 6 months | | | Prior to school | __HepB |
| 18 months | | | | |
| 4-5 years | | | | |

**Child's Peer Relationships**
__Spontaneous __Follower __Leader __Difficulty making friends
__Makes friends easily __Long time friends __Shares easily __Bullying
__Being bullied __Other________________________________________________________________________
Social skills: __Good __Average __Poor

**Cultural/Ethnic**
To which cultural or ethnic group, if any, do you belong? _____________________________________________________
Are you experiencing any problems due to cultural or ethnic issues? __ No __ Yes
If yes, describe ______________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Other cultural/ethnic information ________________________________________________________________________

**Spiritual/Religious**

How important are spiritual matters to you? __Not at all __Little ___ Moderate ___Much

Are you affiliated with a spiritual or religious group? __ No __ Yes

If yes, please describe ____________________

Were you raised within a spiritual or religious group? __ No __ Yes

If yes, please describe ____________________

Would you like your spiritual/religious beliefs incorporated into the counseling? __ No __ Yes

If yes, describe____________________

**Child's Current Legal Status**

**Is your child mandated for treatment? __ No __ Yes**

Is your child involved in any active cases (traffic, civil, criminal)? __No __ Yes

If yes, please describe and indicate the court and hearing/trial dates and charges____________________

____________________

Is your child presently on probation or parole? __ No __ Yes

If yes, please describe ____________________

Probation officers name and telephone number: ____________________

**Child's Past Legal History**

| | Yes | No |
|---|---|---|
| **Traffic Violations** | | |
| **Criminal involvement** | | |
| **DWI, DUI, etc.** | | |
| **Civil involvement** | | |

If you responded yes to any of the above, please fill in the following information

| Charges | Date | Where (city) | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Education**

Current school____________________ School phone number____________________

Type of school __Public __Private __Home schooled Grade/Academic year____________________

Teacher ____________________ School Counselor ____________________

In special education or gifted program? __No __Yes If yes, describe____________________

Has child ever been held back in school? __No __Yes If yes, describe____________________

Which subjects does the child enjoy in school____________________

Which subjects does the child dislike in school____________________

What grades does the child usually receive in school____________________

Have there been any recent changes in the child's grades? __No __Yes If yes, describe____________________

____________________

Has the child been tested psychologically? __No __Yes If yes, describe (bring reports) ____________________

____________________

Current IEP/504 plan in place at school? __No __Yes

**Feelings about schoolwork** (Check the descripts that specifically relate to your child)

__Anxious __Passive __Enthusiastic __Fearful

__Eager __No expression __Bored __Rebellious

__Other ____________________

**Approach to schoolwork**

__Organized __Industrious __Responsible __Interested
__Self-directed __No initiative __Refuses __Does only what is expected
__Sloppy __Disorganized __Cooperative __Does not complete assignments
__Others______________________________________________________________________________

**Performance in school (Parent's/Guardian's Opinion)**

__Satisfactory __Underachiever __Overachiever __Other____________________________________________
Would you like to have the therapist have communication with the school? __No __Yes

**Work**

If the child is involved in a vocational program or works a job, please fill in the following:
What is the child's attitude toward work? __Poor __Average __Good __Excellent
Current employer_________________________ Position____________________ Hours per week________
How have the child's grades in school been affected since working? __Lower __Same __Higher

**Parent's work**:

Father __ Full Time __ Part Time __ Temp __ Laid-off __Disabled __Retired __ Social Security __ Student
__Other:__________________________________________________________________
Mother __ Full Time __ Part Time __ Temp __ Laid-off __Disabled __Retired __ Social Security __ Student
__Other:__________________________________________________________________

**Current Annual Income: Personal Income $____________________ Household Income $___________________**

**Leisure/Recreational**

Describe special areas of interest of hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

| Activity | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Media/Electronics Use:**

__Cellphone __Texting __Computer ___Facebook __Instagram __Twitter __Snapchat
__Videogames __Other______________________________________________________________
Number of hours/day______________________
Do you have conflicts regarding this? (Describe)_____________________________________________
__________________________________________________________________________________

**Medical/Physical/Health**

**Please list all of your child's *CURRENT* medications (prescription and over the counter):**

| Name of medication | What do you use it for? | When did you begin taking it (year) | What is the strength/dosage | How often is it taken | Name of prescribing physician |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please list all of your child's *PAST* medications (prescriptions and over the counter):**

| Name of medication | What was it used for? | How long did you take it? | When did you stop taking it? | Why was it stopped? | Was the medication effective? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Describe your child's overall compliance with the above medications____________________________________________________

**Please list any nutritional and herbal supplements that your child is currently taking** ___________________________________

______________________________________________________________________________________________

**Medication Allergies:** ___________________________________________________________________________

Has your child ever had any bad reactions (made you feel worse) to prior medications? If yes, describe ________________________

______________________________________________________________________________________________

**Does your child see a psychiatrist? Name:** _________________________________ **Last appointment:** ___________________

**Hospital of choice** ______________________________________________ **Phone** _____________________________________

**Address** ________________________________________________________________________________________________

**Most recent examinations:**

| Type of examination | Date of most recent visit | Reason/Results |
|---|---|---|
| Physical exam/Well visit | | |
| Doctor's visit | | |
| Dental examination | | |
| Vision exam | | |
| Hearing exam | | |
| Surgery | | |
| Upcoming surgery | | |

**Physical activity level: ___Low ___Medium ___High**

Child's height ___________ Child's weight ______________

**Physical family health history**

Have any of the following diseases occurred among the child's blood relatives? (Parents, siblings, aunts, uncles, grandparents) Check all that apply

__Allergies __Anemia __ Asthma __Bleeding tendency
__Blindness __Cancer __Cerebral Palsy __Cleft lips
__Cleft palate __Deafness __Diabetes __Glandular problems
__Heart disease __High blood pressure __Kidney disease __Mental retardation
__Migraines __Multiple sclerosis __Muscular Dystrophy __Perceptual motor disorder
__Seizures __Spina Bifida __Other______________________________________________________

Comments regarding family health________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

For each illness listed below, choose a single answer that best describes your CHILD'S health history:

| Condition | Currently | In the past | Never | Condition | Currently | In the past | Never |
|---|---|---|---|---|---|---|---|
| Abortion | | | | Loss of consciousness | | | |
| Anemia | | | | Memory loss | | | |
| Appetite change | | | | Numbness | | | |
| Arthritis | | | | Pain (Daily, longer than 2 weeks) | | | |
| Asthma | | | | Palpitations | | | |
| Back pain | | | | Paralysis | | | |
| Blood in stool | | | | Rheumatic fever | | | |
| Blurred vision | | | | Seizures | | | |
| Caffeine use | | | | Shortness of breath | | | |
| Chest pain | | | | Skin disease | | | |
| Chicken pox | | | | Sleep apnea | | | |
| Chronic cough | | | | Sleep difficulties | | | |
| Colitis or Irritable Bowel | | | | Stroke or TIA | | | |
| Confusion or disorientation | | | | Swallowing difficulty | | | |
| Constipation | | | | Dental problems | | | |
| Diabetes | | | | Thyroid disease | | | |
| Diarrhea | | | | Tuberculosis | | | |
| Dizziness | | | | Ulcers or indigestion | | | |
| Emphysema | | | | Urination difficulty | | | |
| Fainting | | | | Sexually Transmitted Infections | | | |
| Glaucoma | | | | Weakness | | | |
| Gluten allergy | | | | Recent weight gain | | | |
| Head injury | | | | Recent weight loss | | | |
| Headaches (Frequent) | | | | Malnutrition | | | |
| Hearing loss | | | | Epilepsy | | | |
| Heart disease | | | | Autoimmune condition | | | |
| Miscarriage | | | | Hepatitis | | | |
| Infertility | | | | Low energy level | | | |
| Low libido | | | | Other: | | | |
| Multiple sclerosis | | | | | | | |

List any other current health concerns the therapist should be aware of____________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

List any recent health or physical changes______________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Do any of these illnesses significantly challenge or limit your child's ability to function at school or at home? If yes, please provide details___________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

**Self-Care**

**Sleep:**

How many hours of sleep does your child receive in a typical night? _____ Hours

Any problems: __ Falling asleep __ Staying asleep

How many hours of sleep do they need to feel rested? ______ Hours

**Nutrition**

How many consistent meals is your child eating/day?_________________________________________________________

Quantity consumed at meals __Low __Medium __High

Explain:________________________________________________________________________________________

Quality of food eaten __Low __Medium __High

Explain:________________________________________________________________________________________

Is there anything notable abut your child's diet, appetite (gluten free, etc.)?_________________________________

Any foods avoided or do they only eat certain foods?_______________________________________________________

Does your child eat not-edible items?_____________________________________________________________________

**Exercise**

Does your child receive regular exercise? Explain type:___________________________________________________

How often _________week/month

How long do they exercise? __________ min/hours

**Disabilities**

Does your child have any physical/psychological disabilities? __No __Yes

If yes, describe and note how it affects your child's physical and/or psychological functioning and how they adjust to their disability(ies): _________________________________________________________________________________

Have they made an adjustment to the disability/disorder? __N0 __ Yes

Does your child have any need for assistive technology in the provision of counseling services? __No __ Yes

If yes, explaim:___________________________________________________________________________________

**List FAMILY history of mental illness/substance use:**

**Mother = Mo; Father = Fa; Sibling = S; Grandmother = Gm; Grandfather = Gf**

| **Family History of:** | **Currently** | **In the Past** | **Never** |
|---|---|---|---|
| Substance Abuse | | | |
| Depression | | | |
| Anxiety | | | |
| Bipolar | | | |
| Suicide/Homicide Attempt | | | |
| Nervous Breakdown | | | |
| Addictive Behaviors (eating, sexual, etc.) | | | |
| Psychiatric Hospitalizations | | | |

Do any of these illnesses significantly challenge or limit your ability to function at work or at home? If yes, please describe in detail:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**List your CHILD'S history of mental illness/substance abuse**

| Child's History of: | Currently | In the Past | Never |
|---|---|---|---|
| Substance Abuse | | | |
| Depression | | | |
| Anxiety | | | |
| Bipolar | | | |
| Suicide/Homicide Attempt | | | |
| Nervous Breakdown | | | |
| Addictive Behaviors (eating, sexual, etc.) | | | |
| Psychiatric Hospitalizations | | | |

Any additional information that you believe would assist us in understanding your child/adolescent? ______________________________
____________________________________________________________________________________________

**Substance Use History**

| Drug Type | Method | Age at first use | Age at last use | Age of onset of heavy use | Number of days used in the last 30 | Used in last 48 hours? | Used as a rx? | Date of last use | Amount used daily | Amount used weekly | Drug of choice |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol | | | | | | | | | | | |
| Heroine | | | | | | | | | | | |
| Other opiates/painkillers | | | | | | | | | | | |
| Barbiturates/ Sedatives | | | | | | | | | | | |
| Other sedatives | | | | | | | | | | | |
| Tranquilizers | | | | | | | | | | | |
| Meth/Stimulants | | | | | | | | | | | |
| Cocaine | | | | | | | | | | | |
| Crack | | | | | | | | | | | |
| Hallucinogens/ PCP | | | | | | | | | | | |
| Cannabis | | | | | | | | | | | |
| Inhalants | | | | | | | | | | | |
| Antidepressants | | | | | | | | | | | |
| Over the counter | | | | | | | | | | | |
| Nicotine | | | | | | | | | | | |
| Caffeine | | | | | | | | | | | |
| Steroids | | | | | | | | | | | |
| Methadone/ Suboxone | | | | | | | | | | | |
| Benzodiazepines | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Substance(s) of preference**

1. ___________________________________ 3. _______________________________________

2. ___________________________________ 4. _______________________________________

Describe when and where your child typically use substances ___________________________________________________________
_____________________________________________________________________________________________________________

Describe any changes in your child's use patterns_________________________________________________________________
_____________________________________________________________________________________________________________

Describe how your child's use has affected your family or friends (include their perceptions of your use) ___________________ ____
_____________________________________________________________________________________________________________

Reason for use
__ Addicted __Build confidence __Escape __Self-medication
__Socialization __Taste __Other____________________________________________________________________
How do you believe your child's substance use affects your life and your child's life? ___________________________________________
_____________________________________________________________________________________________________________
Who or what has helped your child in stopping or limiting their use?____________________________________________________________
Does/Has someone in your family present/past have/had a problem with drugs or alcohol? __No __Yes
If yes, describe_________________________________________________________________________________________________

**Substance Abuse History Continued**
___Has your use of alcohol or drugs interfered with your obligations at work?
___Has your use of alcohol or drugs interfered with your obligations at school?
___Has your use of alcohol or drugs interfered with your obligations at home?
___Have you used alcohol or drugs while driving a car or truck?
___Have you used alcohol or drugs while operating machinery?
___Have you ever been arrested as a result of drinking or using drugs?
___Have you continued to use alcohol or drugs despite having problems caused by the effects of the substance?
___Have you ever used more alcohol or drugs in order to achieve the desired effect?
___Has there become a markedly diminished effect with the continued use of the same amount of the substance?
___Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?
___Have you ever used substances in larger amounts or over a longer period of time than was initially intended?
___Have you attempted to cut down or control the amount of drinking or drug use without success?
___Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?
___Have important social, occupational, or recreational activities been given up or reduced because of your use of alcohol or drugs?
___Have you continued to use alcohol or drugs despite knowing that physical, psychological, or legal problems are likely to occur?

**Personal Assessment**

| Personal Strengths (Circle all that apply): | Compromising | Creative | Cooperative | Compassionate | Friendly |
|---|---|---|---|---|---|
| | Generous | Hard Working | Honest | Intelligent | Insightful |
| | Open Minded | Open to Therapy | Sense of Humor | Spirituality | Willing to change |
| | Other: ____________________________________ | | | | |

| Individualized Needs (Circle all that apply): | Accessibility | Case Management | | Child Care | Clothing |
|---|---|---|---|---|---|
| | Companionship | Employment | Finances | Food | Health Insurance |
| | Heat | Medical Services | Medications | Safety | Shelter |
| | Social Support | Telephone | Transportation | Coping Skills | |
| | Other: ____________________________________ | | | | |

Abilities/Interests (Circle all that apply): Financial Management  Job Skills  Leadership  Organized  Reader  Recreation  Resourcefulness  Social Skills  Writing
Other: ______________________________________________

Preferences (Please indicate): Day: ______________ Time: ________________
Cultural/Religious/Sexual Considerations: ______________________________
______________________________________________
Aftercare/Discharge planning: ______________________________
Supports: ______________________________________________
Other: ______________________________________________

______________________________  ______________________________
Signature of person filling out form  Date

***DOCUMENT WILL BE REVIEWED DURING INTAKE AND DOCUMENTED ON THE INTAKE ASSESSMENT.**