

Youth Clinical Intake

Parent or Legal Guardian is asked to complete this form for any youth under the age of 18.

Date: _____ Responsible Party: _____

DOB: ____/____/____ SSN#: _____ Insurance: _____

Insured Policy Holder's Name: _____ Insured DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employed at: _____ Work Address: _____

Gross Yearly Income of Household: <\$25,000 <\$50,000 <\$75,000 >\$75,000

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? _____ Referred by: _____

Are you currently involved in church? Yes No If yes, indicate where you attend church and how frequently: _____

Youth's Name: _____ DOB: ____/____/____ SSN#: _____

Gender: Male Female

Youth's Family Member Information

	Name	Age and DOB	Describe Youth's Relationship with Them
Father:			
Mother:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Significant Other:			

Youth's Educational Background

Current School: _____ Teacher: _____ Grade Level: _____

Average Grades: _____ Any Behavior Concerns: Yes No If yes, describe _____

How does the youth get along with others? _____

Does the youth have an Individual Education Plan? Yes No If yes, what is it for? _____

Legal History:

Has the youth ever been arrested? Yes No If yes, indicate arrested for what and when: _____

Developmental History: Does the youth have any developmental delays? Yes No If yes, describe: _____

Trauma History: Has the youth experienced past trauma? Yes No If yes, describe: _____

Medical History: Does the youth have any medical issues? Yes No If yes, describe: _____

Date of last Medical exam: _____ Medical Doctor & Phone #: _____

Christian Counseling Center of Wichita ♦ 333 Greenwood, Wichita, KS 67211 ♦ 316.264.8800

Psychiatric History: Has the youth attended counseling previously? Yes No

When (Specify dates)	Where and with Whom:	Presenting Issues at that time	Diagnosis Given:

Psychotropic Medications: Is the youth currently taking any psychotropic medications? Yes No (specify current & past meds)

Medication	Condition	Dosage	Dates of Usage	Side Effects	Physician

Alcohol/Drug Usage: Does the youth currently use alcohol or drugs? Yes No Used drugs/alcohol in the past? Yes No

Describe the use of drugs and alcohol (type, amount, frequency): _____

When did the youth start using drugs or alcohol? _____

What has the youth's past usage of drugs or alcohol been like? _____

Suicide Risk: Has the youth ever thought about or tried to hurt him or herself? Yes No

If yes, when? _____ How many times? _____

How or what did the youth plan to do? _____

What were the circumstances at the time? _____

Has anyone close to the child/youth ever committed suicide? Yes No If you, who, how, and when: _____

Abuse History: Has the youth ever been physically, emotionally, or sexually abused? Yes No

If yes, briefly explain (who, what, and when): _____

Check the following symptoms/behaviors that the child/youth has experienced in the last thirty days:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Lack of Motivation |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Change in Eating Behavior | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Physical Complaints | <input type="checkbox"/> Easily Annoyed or Irritated | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Uncontrolled Temper Outbursts | <input type="checkbox"/> Guilt, Remorse, Shame | <input type="checkbox"/> Cruelty towards Animals |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Uncontrolled/Unprovoked Crying | <input type="checkbox"/> Lack of Concentration |
| <input type="checkbox"/> Subjective Feelings of Depression | <input type="checkbox"/> Generalized Anxiety | <input type="checkbox"/> Difficulty with Decisions |
| <input type="checkbox"/> Specific Anxiety | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Aggression towards Others |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fear | <input type="checkbox"/> Self-Harming Behavior |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Negativistic | |

Support Systems: Does the youth have people that he/she can turn to for support? Yes No If yes, who? _____

Strengths: What do you feel are the youth's strengths? _____

Presenting Issues: Briefly explain why the youth is seeking counseling at this time: _____

Goals: What do you hope to achieve through counseling? _____