Child Intake: Age 10-17

- ❑ **Fill out initial forms packet.**
- ❑ **Please have the youth or child complete the questionnaires with the help/support of the parent/guardian*
- ❑ **Meet with Intake Coordinator and complete Initial Evaluation and Business Appointment**: Two-hour appointment with Intake Coordinator. Review client information, discuss income and client rights, discuss goal for treatment, discuss available services.
- ❑ **Schedule first appointment with provider.**

You must complete these two steps before you are able to see the provider and receive medication.

- ❑ **Meet with Therapist to complete the Assessment and Comprehensive Care Plan**: Three-hour appointment with therapist. Identify and complete assessment including substance abuse assessment and create comprehensive service plan.
- ❑ **Able to schedule another appointment with provider**: Once the above step has been completed, you will be able to see the provider.

You must complete the step above in order for you to continue to see the provider. If the assessment appointment is not completed, all medication appointments will be cancelled until the assessment appointment is completed.

Please make sure to fill out each page completely.

Counseling + Recovery SERVICES

Baseline TB Screening

ID Number:_____

Name: _____ **Date**: _____

Below are questions for identifying those who may be at risk of TB infection; and for whom testing might be indicated.

1. Has you child ever been tested for TB?	Yes	No
2. If so, TB test Date: _____		
3. Is your child HIV+?	Yes	No
4. Has your child ever had a positive TB skin test or TB blood test?	Yes	No
5. If so, when: _____		
6. Have you worked in health care, or stayed in a homeless shelter, jail, or prison for more than 8 hours at a time in the past year?	Yes	No
7. Has your child lived with or spent more than 8 hours at a time with someone who you knew was sick from TB?	Yes	No
Where was your child born? State/Country		

Staff Only:

{It is recommended that anyone who answers *yes* to any of **1-4** should be tested annually.

Per #5, it is recommended that anyone born outside the US should also be tested **annually**}

Recommendation

☐ Refer client for testing to rule out active TB disease (Tulsa Co. Health Department).

☐ Annually re-testing required

☐ No recommendation

Counseling + Recovery SERVICES

GAD-7 Anxiety

ID Number:_____

Name: _____ **Date**: _____

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "X" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Counseling + Recovery SERVICES

PHQ-A

ID Number:_____

Name: _____ **Date**: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "X" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling down, depressed, irritable, or hopeless.....……	0	1	2	3
2. Little interest or pleasure in doing things.……...……	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....……...……..	0	1	2	3
4. Poor appetite, weight loss, or overeating.....……...……	0	1	2	3
5. Feeling tired or having little energy.....……...……	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down……..	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV……..	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....……..	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....……	0	1	2	3

In the past year have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Counseling + Recovery SERVICES

GAIN-SS

What is your name? a._____ b. _____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something.	4	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
d. Had a hard time waiting for your turn.	4	3	2	1	0
e. Were a bully or threatened other people.	4	3	2	1	0
f. Started physical fights with other people	4	3	2	1	0
g. Tried to win back your gambling losses by going back another day	4	3	2	1	0

2h. When was the **last** time, if ever, you were treated for a mental, emotional, behavioral or psychological problem by a mental health specialist or in an emergency room, hospital or outpatient mental health facility, or with prescribed medication? 4 3 2 1 0

ID Number:_____

Name: _____ **Date**: _____

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

SDScr 3. **When was the last time that...**

a. you used alcohol or other drugs weekly or more often? 4 3 2 1 0

b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)? 4 3 2 1 0

c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 4 3 2 1 0

d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events? 4 3 2 1 0

e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? 4 3 2 1 0

f. you received treatment, counseling, medication, case management or aftercare for your use of alcohol or **any other drug**? Please do not include any emergency room visits, detoxification, self-help or recovery programs 4 3 2 1 0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone? 4 3 2 1 0

b. took something from a store without paying for it? 4 3 2 1 0

c. sold, distributed, or helped to make illegal drugs? 4 3 2 1 0

d. drove a vehicle while under the influence of alcohol or illegal drugs? 4 3 2 1 0

e. purposely damaged or destroyed property that did not belong to you? 4 3 2 1 0

f. were involved in the criminal justice system, such as jail or prison, detention, probation, parole, house arrest or electronic monitoring? 4 3 2 1 0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

_____

6a. Which races, ethnicities, nationalities or tribes best describe you? (Any others?) (**Please record and select all that apply**)

v1. _____

ID Number:_____

Name: _____ **Date**: _____

Please select at least one race.

	MENTIONED	
	Yes	No
1. Alaskan Native **(Please record tribe in 6a1)**	1	0
2. Asian	1	0
3. African American/Black	1	0
4. Caucasian/White	1	0
5. Hispanic, Latino or Chicano	1	0
a. Puerto Rican	1	0
b. Mexican	1	0
c. Cuban	1	0
e. Dominican	1	0
f. Other Central American	1	0
g. Other South American	1	0
z. Other **(Please record tribe in 6a1)**	1	0
6. Native American **(Please record tribe in 6a1)**	1	0
7. Native Hawaiian	1	0
8. Pacific Islander	1	0
9. Some other group **(Please record tribe in 6a1)**	1	0

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|___| minutes

Counseling + Recovery SERVICES

Child & Youth Health Risk Appraisal

ID Number:_____

Name: _____ **Date**: _____

Who is completing this form? ☐Self ☐Parent/Guardian ☐Other:

_____

Do you have any concerns about your child's general health, development or behavior?

☐ Yes ☐ No

Does your child/youth have any of the following medical conditions?

☐Asthma ☐Diabetes ☐Seizure Disorder

☐Heart Disease ☐High Cholesterol ☐High Blood Pressure

Please list any other physical health condition (including surgeries) that you feel is important for us to know:

_____

_____

Does your child need any of the following:

Primary Care Physician	☐Has	☐Need	**Eye Doctor**	☐Has	☐Need
Dentist	☐Has	☐Need	**Audiologist**	☐Has	☐Need
Medical Equipment	☐Has	☐Need	**Other Specialist**	☐Has	☐Need

Has your child had a **physical examination** in the last 12 months?

☐Yes ☐ No ☐ Unknown

Has your child had an **eye exam** in the last 12 months? ☐Yes ☐ No ☐ Unknown

Has your child had a **dental exam** in the last 12 months? ☐Yes ☐ No ☐ Unknown

Does your child have any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)? ☐Yes ☐ No ☐ Unknown

Does your child have any allergies (food, medication, latex, etc.)? ☐Yes ☐ No ☐ Unknown

Does your child take any medications? ☐ Yes ☐ No

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

If yes, please list. Include vitamins, supplements, and over-the-counters (daily or occasional)

_____

_____

_____

_____

In the last 12 months has your child experienced any difficulty with wheezing or excessive night coughing? ☐Yes ☐No ☐Unknown

In the last 12 months, has your child experienced any noticeable weight loss or weight gain, or excessive thirst or urination? ☐ Yes ☐No ☐Unknown

Does your child use any special medical equipment in the home? ☐Yes ☐No

Does your child use any mobility tools to help him/her walk/move? ☐Yes ☐No

Has your child been to an Emergency Room within the last 3 months? ☐Yes ☐No

If yes, where?_____

Has your child been **admitted to the hospital** in the last 3 months? ☐Yes ☐No

If yes,
where?_____

Does your child see more than one doctor? ☐Yes ☐No

If yes, please list: _____

Does your child need immunizations? ☐Yes ☐No ☐Unknown

Has your child had a lead screen? ☐Yes ☐ No ☐Unknown

Is your child around cigarettes/cigars/pipes on a regular basis? ☐ Yes ☐ No

Is your child around drugs and alcohol on a regular basis? ☐ Yes ☐ No

How many hours of sleep does your child usually get each night? _____ hours

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

Does your child snore? ☐Yes ☐ No

Does your child mouth breathe? ☐Yes ☐ No

How many **days** per week does your child usually get exercise? _____ days

How many **hours** per day does your child usually get exercise? _____ hours

How many hours of screen time (computer/smart phone/tablet/gaming systems/television) does your child have a day? _____ hours

On a typical day, how many servings of fruits and/or vegetables does your child eat? (1 serving= 1 cup fresh or ½ cup cooked vegetables) _____ servings per day

Does your child drink plenty of water every day? ☐ Yes ☐ No

How many sodas or energy drinks does your child drink in a day?_____drinks

Is your child sexually active? ☐ Yes ☐ No

What is/are his/her methods for protecting against pregnancy?

_____

_____

_____

What is/are his/her methods for protecting against STDs?

_____

_____

_____

Does your child take a multivitamin? ☐ Yes ☐ No

Does your child put on sunscreen before spending extended time outside? ☐ Yes ☐ No

Does your child always fasten his/her seatbelt when in a car? ☐ Yes ☐ No

In general, would you say your child's physical health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

OKSOC Assessment-Caregiver Version

Assessment Type: Baseline

**Parent/Guardian please fill out the below questionnaire.*

OKSOC Family Assessment	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1. We get along in my family.	0	1	2	3	4	5
2. We know how to work problems out in my family.	0	1	2	3	4	5
3. I feel safe in my home.	0	1	2	3	4	5
4. I know what the rules are in my family.	0	1	2	3	4	5
5. We trust each other in my family.	0	1	2	3	4	5
6. You can say what you really think in my family.	0	1	2	3	4	5
7. My family is there for me.	0	1	2	3	4	5
8. I know what to expect from my family.	0	1	2	3	4	5
9. It's ok to talk about my feelings with my family.	0	1	2	3	4	5
10. My family spends time having fun.	0	1	2	3	4	5

Hopefulness Scales

1. Overall, how satisfied are you with your relationship with your child right now?
   - 6 Extremely satisfied
   - 5 Moderately satisfied
   - 4 Somewhat satisfied
   - 3 Somewhat dissatisfied
   - 2 Moderately dissatisfied
   - 1 Extremely dissatisfied

2. How capable of dealing with your child's problems do you feel right now?
   - 6 Extremely capable
   - 5 Moderately capable
   - 4 Somewhat capable
   - 3 Somewhat incapable
   - 2 Moderately incapable
   - 1 Extremely in capable

3. How much stress or pressure is in your life right now?
   - 6 Very little
   - 5 Some
   - 4 Quite a bit
   - 3 A moderate amount
   - 2 A great deal
   - 1 Unbearable amounts

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

4. How optimistic are you about your child's future right now?
   - 6 The future looks very bright.
   - 5 The future looks somewhat bright.
   - 4 The future looks ok.
   - 3 The future looks both good and bad.
   - 2 The future looks bad.
   - 1 The future looks very bad.

Youth Problem Scale **Instructions:** Please rate the degree to which your child has experienced the following problems in the past 30 days.		**Not at All**	**Once or Twice**	**Several Times**	**Often**	**Most of the Time**	**All of the Time**
1.	Arguing with others	0	1	2	3	4	5
2.	Getting into fights	0	1	2	3	4	5
3.	Yelling, swearing, or screaming at others	0	1	2	3	4	5
4.	Fits of anger	0	1	2	3	4	5
5.	Refusing to do things teachers, parents, or employers ask	0	1	2	3	4	5
6.	Causing trouble for no reason	0	1	2	3	4	5
7.	Using drugs or alcohol	0	1	2	3	4	5
8.	Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9.	Skipping school, classes, or work	0	1	2	3	4	5
10.	Lying	0	1	2	3	4	5
11.	Can't seem to sit still, having too much energy	0	1	2	3	4	5
12.	Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13.	Talking or thinking about death	0	1	2	3	4	5
14.	Feeling worthless or useless	0	1	2	3	4	5
15.	Feeling lonely and having no friends	0	1	2	3	4	5
16.	Feeling anxious or fearful	0	1	2	3	4	5
17.	Worrying that something bad is going to happen	0	1	2	3	4	5
18.	Feeling sad or depressed	0	1	2	3	4	5
19.	Nightmares	0	1	2	3	4	5
20.	Eating problems	0	1	2	3	4	5
	TOTALS						
Problems Score of 25 and above = *Critical Impairment*						**TOTAL**	

Counseling + Recovery SERVICES

Youth Functioning Scale **Instructions:** Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal, employer)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4
TOTALS					
Functioning Score of 44 and below = *Critical Impairment*				**TOTAL**	

ID Number:_____

Name: _____ **Date**: _____

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

OKSOC Assessment-Youth Version

Assessment Type: Baseline

**If appropriate, the child/youth please fill out the below questionnaire.*

OKSOC Family Assessment	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
1. We get along in my family.	0	1	2	3	4	5
2. We know how to work problems out in my family.	0	1	2	3	4	5
3. I feel safe in my home.	0	1	2	3	4	5
4. I know what the rules are in my family.	0	1	2	3	4	5
5. We trust each other in my family.	0	1	2	3	4	5
6. You can say what you really think in my family.	0	1	2	3	4	5
7. My family is there for me.	0	1	2	3	4	5
8. I know what to expect from my family.	0	1	2	3	4	5
9. It's ok to talk about my feelings with my family.	0	1	2	3	4	5
10. My family spends time having fun.	0	1	2	3	4	5

Hopefulness Scales

1. Overall, how satisfied are you with your life right now?
   - 6 Extremely satisfied
   - 5 Moderately satisfied
   - 4 Somewhat satisfied
   - 3 Somewhat dissatisfied
   - 2 Moderately dissatisfied
   - 1 Extremely dissatisfied

2. How energetic and healthy do you feel right now?
   - 6 Extremely energetic and healthy
   - 5 Moderately energetic and healthy
   - 4 Somewhat energetic and healthy
   - 3 Somewhat unenergetic and unhealthy
   - 2 Moderately unenergetic and unhealthy
   - 1 Extremely unenergetic and unhealthy

3. How much stress or pressure is in your life right now?
   - 6 Very little
   - 5 Some
   - 4 Quite a bit
   - 3 A moderate amount
   - 2 A great deal
   - 1 Unbearable amounts

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

4. How optimistic are you about your future right now?

6	The future looks very bright.	3	The future looks both good and bad.
5	The future looks somewhat bright.	2	The future looks bad.
4	The future looks ok.	1	The future looks very bad.

Problem Scale **Instructions:** Please rate the degree to which you have experienced the following problems in the past 30 days.		Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1.	Arguing with others	0	1	2	3	4	5
2.	Getting into fights	0	1	2	3	4	5
3.	Yelling, swearing, or screaming at others	0	1	2	3	4	5
4.	Fits of anger	0	1	2	3	4	5
5.	Refusing to do things teachers, parents, or employers ask	0	1	2	3	4	5
6.	Causing trouble for no reason	0	1	2	3	4	5
7.	Using drugs or alcohol	0	1	2	3	4	5
8.	Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9.	Skipping classes or work	0	1	2	3	4	5
10.	Lying	0	1	2	3	4	5
11.	Can't seem to sit still, having too much energy	0	1	2	3	4	5
12.	Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13.	Talking or thinking about death	0	1	2	3	4	5
14.	Feeling worthless or useless	0	1	2	3	4	5
15.	Feeling lonely and having no friends	0	1	2	3	4	5
16.	Feeling anxious or fearful	0	1	2	3	4	5
17.	Worrying that something bad is going to happen	0	1	2	3	4	5
18.	Feeling sad or depressed	0	1	2	3	4	5
19.	Nightmares	0	1	2	3	4	5
20.	Eating problems	0	1	2	3	4	5
	TOTALS						
Problems Score of 25 and above = *Critical Impairment*						**TOTAL**	

Counseling + Recovery SERVICES

ID Number:_____

Name: _____ **Date**: _____

Functioning Scale **Instructions:** Please rate the degree to which your problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal, employer)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending class/going to work and being successful	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4
TOTALS					
Functioning Score of 44 and below = *Critical Impairment*				**TOTAL**	

YOUTH AND YOUNG ADULT CLIENT INFORMATION

Date ____/____/____ Referred by _____

CLIENT INFORMATION

Name _____ Preferred Name _____

DOB ____/____/____ Social Security ____|____|____

Age _____ Gender _____ Race _____

PARENT / GUARDIAN INFORMATION

Name _____ Phone _____

Relationship Mother Father Foster Parent Other

Adoptive Mother Adoptive Father

Name _____ Phone _____

Relationship Mother Father Foster Parent Other

Adoptive Mother Adoptive Father

Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

EMERGENCY INFORMATION

Emergency Contact _____

Relationship _____ Phone _____

INSURANCE AND FINANCIAL INFORMATION

Insurance Medicaid Medicare Private Self-pay

Please flip over and complete page 2

INSURANCE AND FINANCIAL INFORMATION CONT.

Insured's Name ________________ Policy Holder ________________

Policy Number ________________ Group Number ________________

Number in Household ________________ Total Household Income ________________

CLINICAL INFORMATION

Are you currently having suicidal thoughts? Yes | No

Are you currently having homicidal thoughts? Yes | No

Have you ever had suicidal/homicidal thoughts? Yes | No

When is the last time you thought about harming yourself or someone else? Date ________

MEDICAL INFORMATION

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Medication Name ________________
Dosage/Frequency ________________
Side Effects ________________
Prescribing Physician ________________

Allergies ________________________________ None ________

Primary Care Doctor ________________ Phone ________

Please flip over and complete page 3

ADDITIONAL INFORMATION		
Does your child require special help, accommodations, or equipment	Yes	No
If yes, what assistance is needed? _____		
Is your child receiving services somewhere else?	Yes	No
If yes, where? _____		
Is your child a current or former client?	Yes	No
Last seen _____		