Case Number: ________________

Family Counseling and Children's Services of Lenawee County

Child Intake Assessment

Client's Name: ____ Date of Intake: ___________

Gender: _____________ Date of Birth: ______________ Age: __________

Please answer questions in the unboxed areas of the form only.

Primary reason(s) for seeking services at this time (please check all that apply):

____ ADHD	____ Eating Disorder	____ Relationship Issues
____ Anxiety	____ Grief	____ Substance Abuse
____ Depression	____ Repeated Behaviors	____ Traumatic Experience

Other mental health concerns (specify):

____

Current Life Stressors (please check all that apply):

____ Environment	____ Health	____ Peer Conflicts
____ Family	____ Job	____ Relationship
____ Finances	____ Legal Issues	____ School

Other life stressors you are currently experiencing (specify):

____

Shaded area for therapist use only

Family History and Environmental Information

Parents:

With whom does the child live at this time? ____

Were the child's parents ever married? _____ Yes _____ No

Are parent's divorced or separated? _____ Yes _____ No

If yes, who has legal custody? ____

Has the child ever been placed outside of the home? _____ Yes _____ No

If yes, where? ____

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): ____________

Client's Mother:

Name: ____ Age: _________

Is the child currently living with mother? _____ Yes _____ No

_____ Natural Parent _____ Step-Parent _____ Adoptive Parent _____ Foster Home _____ Other

Is there anything unusual or stressful about the child's relationship with the mother?

____

____

Client's Father:

Name: ____ Age: _________

Is the child currently living with father? _____ Yes _____ No

_____ Natural Parent _____ Step-Parent _____ Adoptive Parent _____ Foster Home _____ Other

Is there anything unusual or stressful about the child's relationship with the father?

____

____

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

Names of Siblings	Gender	Age	Lives	Quality of Relationship
____________________	F/M	______	Home/Away	Poor/Average/Good
____________________	F/M	______	Home/Away	Poor/Average/Good
____________________	F/M	______	Home/Away	Poor/Average/Good
____________________	F/M	______	Home/Away	Poor/Average/Good
____________________	F/M	______	Home/Away	Poor/Average/Good

Names of Others Living in the Household	Relationship	Gender	Age	Quality of Relationship
____________________	____________	F/M	______	Poor/Average/Good
____________________	____________	F/M	______	Poor/Average/Good
____________________	____________	F/M	______	Poor/Average/Good

______________________________________ _______________ F/M _____ Poor/Average/Good
______________________________________ _______________ F/M _____ Poor/Average/Good

To which cultural or ethnic group, if any, does the client belong? ____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If yes, describe: ____

Spirituality

Is spirituality an area of support or strength for the client? ____ Yes ____ No

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

If yes, describe: ____

Are you content with your level of activity in regards to spirituality? ____ Yes ____ No

Education

Current School: ____ Grade: _________________

Is client currently in a special program? ____ Yes ____ No

If yes, what type? ____

Has client ever been held back in school? ____ Yes ____ No

If yes, which grade? ____

Has client ever:

Been suspended: ____ Yes ____ No Been expelled: ____ Yes ____ No

Have there been any recent changes in the client's grades? ____ Yes ____ No

If yes, please describe: ____

Approach to School Work (check all that apply):

____ Organized ____ Responsible ____ Interested ____ Self-Directed

____ No Initiative ____ Refuses ____ Sloppy ____ Disorganized

____ Does not complete assignments ____ Does only what is expected

____ Other (describe): ____

Client's Peer Relationships (check all that apply):

____ Follower ____ Leader ____ Difficulty Making Friends ____ Makes Friends Easily

____Other (describe): ____

Leisure Activities

How does client spend non-school time (hobbies, activities, talents)?

____

____

Medical/Physical Health

List any current physical health concerns: ____

____

____

____

Current prescribed medications	Dose	Purpose	Side Effects
______________________	_____	____________	_________________
______________________	_____	____________	_________________
______________________	_____	____________	_________________
______________________	_____	____________	_________________

Most recent examinations	Date	Reason	Results
Last physical exam	________	_________________	______________________
Last doctor's visit	________	_________________	______________________

Family history of medical problems (describe): ____

____

____

Have you ever had a head injury? ____ Yes ____ No

Do you have a current issue or past history of self-injury (cutting, burning, etc.)? ____ Yes ____ No

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General mood ____ Weight ____ Nervousness

Mental Health:

Have you ever participated in counseling before? _____ Yes _____ No

If yes, who was your treatment provider? ____

Have you ever been involved with self-help groups? _____ Yes _____ No

If yes, what topic? ____

Have you ever been hospitalized for issues related to mental health? _____ Yes _____ No

If yes, when and where? ____

Have you ever had thoughts of suicide or made attempts at suicide? _____ Yes _____ No

Do you feel suicidal at this time? _____ Yes _____ No

Have you ever experienced homicidal thoughts? _____ Yes _____ No

Do you feel homicidal at this time? _____ Yes _____ No

Is there a family history of mental illness? _____ Yes _____ No

If yes, please describe: ____

____

____

Substance Use (to be answered by client):

Does client use or have a problem with alcohol or drugs? ____ Yes ____ No

If yes, complete information below:

Substance of preference

1. ______________________________ 2. ______________________________

Describe when and where you typically use substances:

____

____

Reason(s) for use (check all that apply):

____ Addicted ____ Build Confidence ____ Escape ____ Self-Medication

____ Socialization ____ Taste ____ Other (specify): ______________________

Has someone in your family had a problem with drugs or alcohol? ____ Yes _____ No

If yes, describe: ____

Have you ever participated in substance abuse counseling? ____ Yes ____ No

If yes, who was your treatment provider? ______________________________________

Legal:

Has the client ever: Had difficulty or contact with the police? _____ Yes _____ No

Appeared in juvenile court? _____ Yes _____ No

Been on probation? _____ Yes _____ No

If yes to any of the above, describe circumstances:

____
____
____
____

MENTAL STATUS:

General Behavior: Cooperative, passive, withdrawn, hostile, anxious, other___________________________

Attire: Appropriate, seductive, untidy, loud, meticulous, other____________________________

Gait: Normal, erect, stooped, rigid, shuffling, other______________________________________

Motor Activity: Normal, agitated, retarded, tic, mannerism, other__________________________________

Stream of thought and communication:

Productivity: Spontaneous, verbose, pressured speech, unproductive, other____________________

Progression: Normal, loose, halting, incoherent, fragmented, other_____________________________

Language: Normal, baby talk, rambling, impediment, verbose, profane, other _______________

Emotional tone and reactions:

Mood/Affect: Indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, normal composed, anxious, tearful, depressed, other_______________________________________

Mental Trend/Content of thoughts:

Perception: Normal, auditory, hallucinations, visual hallucinations, illusions, depersonalization, delusions of grandeur, other____

Orientation: Normal, disoriented to time, place, person, other_________________________________

Memory: Normal, defective, (remote, recent, immediate)

General Knowledge: Consistent with education, inconsistent, explain if needed:_______________________

Insight: Absent, good fair, minimal

Judgment: Good, fair, poor

Diagnostic Summary:

DIAGNOSTIC IMPRESSIONS (DSM-5 Code and Diagnosis)

____

____

____

____

METHOD OF DATA COLLECTION: □ **Client Self Report** □ **Clinical Observation** □ **Self-Rating Scale** □ **Court Report** □ **Other:** ______________________________

Document all unmet needs and service gaps and provide an explanation for needs/problems that have not been addressed and referrals that have been made:

____

____

____

Indicate all those who have been involved in services planning for this client.

____

____

____

INITIAL PROBLEM AREA/NEED: ______________________________

____

____

____

TREATMENT GOAL: **TARGET DATE**

____

____

____

____

OBJECTIVES:

____

____

____

____

INTERVENTIONS:

____

____

____

____

Service recommendations: ☐ **Brief solution based (5-10 sessions)** ☐ **Long term therapy (10+ sessions)**

- ☐ **Individual** ☐ **Family**
- ☐ **Group** ☐ **Pregnancy counseling**
- ☐ **Marital or premarital** ☐ **Other: __________________________**
- ☐ **Counseling for recent trauma victim (may need more frequent monitoring)**

Client's comments:

____

____

Does the client agree with the IPS ☐ **Yes** ☐ **No** ☐ **Cannot determine**
Psychiatric consult requested ☐ **Yes** ☐**No**
I hereby authorize Family Counseling and Children's Services to provide the above services.

____ ___________________
Parent/Guardian Signature **Date**

____ ___________________
Client's Signature **Date**

____ ___________________
Therapist Signature **Date**

Supervisor's comments:

____

____

____ ___________________
Supervisor's Signature **Date**