



INSTRUCTIONS: The Family Information Form must be filled out accurately and completely. Please answer all questions. Do not leave any items blank. If an item does not apply, write N/A (not applicable).

TODAY'S DATE: _____

HOW DID YOU LEARN ABOUT OUR SERVICES?

Community Agency Court Hospital Legal Private Practitioner School Self Other

SPECIFY: _____

HOUSEHOLD INCOME:

\$0 - \$24,999 \$25,000 - \$49,999 \$50,000 - \$99,999 Over \$100,000

DO YOU HAVE TRANSPORTATION?

Yes No Type: _____

I. CLIENT'S INFORMATION

FULL NAME OF PERSON WITH WHOM CHILD LIVES: _____

RELATIONSHIP TO CHILD: _____

First Name

M. Initial

Last Name

Date of Birth

Age

GENDER IDENTIFICATION (CHECK ONE):

Female Male FTM (female to male transgender)
 MTF (male to female transgender) OTHER (please specify) _____

RACE: White Black Asian Native American
 Native Hawaiian/Pacific Islander Two or More/Multiracial

ETHNICITY:
 Hispanic Non/Hispanic

PRIMARY LANGUAGE SPOKEN: English Spanish
 French Creole OTHER (please specify): _____

ENGLISH PROFICIENCY LEVEL:
 Fluent Limited None

NEED INTERPRETER?
 Yes No

PARENTAL STATUS:
 Biological Adoptive Foster Stepparent
 N/A Child OTHER (explain): _____

CURRENT MARITAL STATUS:
 Married Divorced Separated
 Widowed Living Together N/A Child
 Single/Never Married

Country of Birth

Grade

School/Employer

Student #

HIGHEST EDUCATION:

Elementary Middle High School Diploma/GED
 Some College/Associates Bachelor's Degree
 Master's Degree Doctorate

EMPLOYMENT STATUS:

Employed Unemployed Retired
 N/A Child

Address

City

Zip Code

_____ Country of Birth _____ Address _____ City _____ Zip Code
 _____ Occupation _____ Employer _____ # of years employed

HIGHEST EDUCATION: <input type="checkbox"/> Elementary <input type="checkbox"/> Middle <input type="checkbox"/> High School Diploma/GED <input type="checkbox"/> Some College/Associates <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate			EMPLOYMENT STATUS: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> N/A Child		
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Cell#	OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work#	OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home#	OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No
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III. OTHER ADULTS AND CHILDREN LIVING AT HOME

NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD: _____

_____ First Name _____ M. Initial _____ Last Name _____ Date of Birth _____ Age
 _____ Country of Birth _____ Grade _____ School/Employer _____ Relationship to child

GENDER IDENTIFICATION (CHECK ONE): <input type="checkbox"/> Female <input type="checkbox"/> FTM (female to male transgender) <input type="checkbox"/> Male <input type="checkbox"/> MTF (male to female transgender) <input type="checkbox"/> Other (please specify): _____	RACE: <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Two or More/Multiracial	ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non/Hispanic
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_____ First Name _____ M. Initial _____ Last Name _____ Date of Birth _____ Age
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 First Name M. Initial Last Name Date of Birth Age

 Country of Birth Grade School/Employer Relationship to child

GENDER IDENTIFICATION (CHECK ONE): <input type="checkbox"/> Female <input type="checkbox"/> FTM (female to male transgender) <input type="checkbox"/> Male <input type="checkbox"/> MTF (male to female transgender) <input type="checkbox"/> Other (please specify): _____	RACE: <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Two or More/Multiracial	ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non/Hispanic
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IV. MEDICAL/PSYCHIATRIC HISTORY

1. Is your youth currently taking medication? Yes No List: _____
2. Has your youth previously taken medication? Yes No List: _____
3. Is youth/family currently receiving services from another agency/professional? Yes No
 List:

4. Has youth/family received prior services from another agency/professional? Yes No
 List:

5. Does youth have a history of psychiatric hospitalization? Yes No
 List:

6. History of specialized school services:
 - a. Individualized Education Plan (IEP) Current Past Never
 - b. 504 Accommodation Plan Current Past Never
 - c. Response to Intervention (RTI) Current Past Never
 - d. Speech or Occupational Therapy Current Past Never
 - e. Language/ESOL Current Past Never
 - f. Other (please specify): _____

V. QUESTIONNAIRE: Please answer **“current”** (last 6 months), **“past”** (over 6 months), or **“never”** to ALL items listed below.

SCHOOL CONCERNS	Current	Past	Never	COURT/LEGAL INVOLVEMENT	Current	Past	Never
Poor grades	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Court ordered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Court referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive absences/Skips class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Family Violence Intervention (FVIP)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Juvenile Diversion Alternative (JDAP)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated a grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Youth Firesetters Intervention (YFIP)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School detentions/referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Youth Court</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School expulsion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DCF referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School referred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family legal involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Truant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL CONCERNS	Current	Past	Never
BEHAVIORAL CONCERNS	Current	Past	Never	Anxious/Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention seeking behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disrespectful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grief/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disruptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harms animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SOCIAL CONCERNS	Current	Past	Never
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bullying others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bullied by others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dangerous neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physically aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive gaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Profanity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor peer group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social media misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual behavior problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social skills issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soils clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FAMILY CONCERNS	Current	Past	Never
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Domestic violence			
Urinates in clothes or bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbally aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUBSTANCE USE	Current	Past	Never	<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use concerns				Emotional abuse			
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug use concerns				Incarceration			
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Medical concerns			
				<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY CONCERNS CONT'D				STRENGTHS			
	Current	Past	Never		Current	Past	Never
Mental health concerns				Best friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Community involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extra –curricular activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extended family contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neglect				Family has fun together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Good grades	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Handles stress well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse				Intelligent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likes school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Likes teacher (s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent support each other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent divorce/separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safe neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse				Solves problem efficiently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual or religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Works at part-time job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling rivalry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Weapons in the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Youth pregnancy/birth							
<i>Youth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Parent</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<i>Other Family Member</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Other Concerns (youth/family):

Other Strengths (youth/family):

What do you hope will change by participating in our services?

VI. CONSENT FOR INTAKE ASSESSMENT SERVICES:

My signature below indicates that I consent to participate in the Intake Assessment process with the Youth Services Department.

The Youth Services Department provides training for mental health counseling, marriage and family therapy, clinical social work, and psychology graduate students and postgraduates in need of clinical experience for licensure. Trainees are able to provide services while under the supervision of a licensed mental health professional.

I agree to have my intake assessment completed by a trainee. Yes No

Youth Printed Name

Youth Signature

Parent Printed Name

Parent Signature

Parent Printed Name

Parent Signature