Youth Intake Interview Form

Today's Date:_____

Youth's Name_____
First **Middle** **Last**

Address:_____ Birth Date:_____

_____ Male/Female:_____

Phone: (___)_____ Social Security #:_____

Place of Birth:_____ Insurance Co:_____

Mother's Name_____ Father's Name_____

DOB:_____ Occupation:_____ DOB:_____ Occupation:_____

Address_____ Address_____

_____ _____

Phone (H)_____(W)_____ Phone (H)_____(W)_____

Persons Present for Assessment:_____

Self identified race/ethnicity/cultural heritage_____

Language youth/family speak at home (if not English)_____

EDUCATIONAL INFORMATION

School Building:_____Grade:_____

Credits:_____ GPA:_____ IEP?__No ___Yes:_____

Ever been diagnosed with ADHD?__No ___Yes:_____

Attendance Pattern: ____Regular ____Skips ____Tardies

What are your Academic Goals?:__GED ___Diploma ___Trade School ___College
Explain:_____

Do you participate in any school sports?_____

_____

Are you in any clubs or other school activities?_____

_____

What do you like best about school?_____

What do you like least about school?_____

What is your favorite class/subject?_____

Have you ever been suspended?___No ___Yes:_____

_____

Have you ever been expelled?___No ___Yes:_____

_____

Do you have a history of fighting in school?___No ___Yes:_____

_____

Is there a teacher, counselor, coach, or other adult at school that you can talk to?___No ___Yes:__

_____

Guidance Counselor:_____

Do the parents help/support youth in school?___No ___Yes:_____

How did youth do in school in the past? (elementary, middle school, grades, fighting, suspensions):

_____

_____

_____

_____

Additional Notes:_____

_____

_____

_____

_____

_____

_____

FAMILY STRUCTURE/LIVING SITUATION

Individual Lives with:

___Father ___Stepfather ___Legal Adoption
___Mother ___Stepmother ___Relatives:_____
___Both (biological) ___Other:_____

Who else lives in the home? (siblings, relatives, significant others, etc.)_____

_____

Home Environment:

Describe the relationships and communication within the home (conflicts, how people get along):_____

_____

_____

_____

_____

What are your rules at home?_____

_____

What consequences do you typically face when you don't follow the rules?_____

What consequences did you face at home for this referral?_____

What are some things you do together as a family?_____

Significant family events, traumas, or major changes/Dates:_____

What are some strengths you have as a family?_____

What adult do you spend most of your time with? (Looking for a positive adult role model)
Name:_____ Relationship:_____

Which extended family members provide support and how?
Name:_____ Relationship:_____

History of running away:___No ___Yes**:** (How often, most recent occurrence)_____

Any previous out of home placements?:_____

Family Criminal History:
Mother: ___No ___Yes, Crime(s):_____
Father: ___No ___Yes, Crime(s):_____
Siblings: ___No ___Yes, Crime(s):_____
Relatives: ___No ___Yes, Crime(s):_____

Additional Notes:_____

YOUTH

What do you like to do for fun? (favorite hobbies/interests)_____

What are some things that you're good at?_____

What are some things your child is good at?_____

_____

How would you describe yourself?_____

_____

Do you go to any youth groups, church groups, or clubs?_____

_____

Have you ever had a job?_____

_____

Are there positive people in your life who serve as a resource/mentor for you?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Additional Notes:_____

_____

_____

_____

PEERS

How would you describe your friends?_____

_____

___Lots of Friends ___Few Friends ___No Friends

___Mostly Older ___Mostly Younger ___Same Age

Do parents know and approve of friends?___No ___Yes, Comments:_____

_____

Have your friends changed over time? How/Why?_____

_____

Have any of your friends gotten into trouble with the law?___No ___Yes:_____

_____

How do your friends do in school? (grades, attendance, behavior)_____

_____

What do you value in a friend?_____

MEDICAL

Does youth, or has youth ever, taken medication?____No____Yes:_____

_____

_____

_____

Any pregnancy, delivery, or developmental milestone (walking, talking, potty training) concerns?

_____

_____

Is there any history of head injury?___No ___Yes:_____

_____

Any past hospitalizations, serious injuries, or frequent or chronic illnesses?_____

_____

_____

MENTAL HEALTH

Have you ever received any psychological or counseling services?___No ___Yes:_____

_____

_____

_____

Have you ever attempted suicide?___No ___Yes:_____

_____

Have you ever had suicidal thoughts or gestures?___No ___Yes:_____

Any history of depression or withdrawal?___No ___Yes:_____

Any history of sleeping or eating problems?___No ___Yes:_____

Any auditory or visual hallucinations?___No ___Yes:_____

Family History of Mental Illness:

Mother: ___No ___Yes, Explain:_____
Father: ___No ___Yes, Explain:_____
Siblings: ___No ___Yes, Explain:_____
Relatives: ___No ___Yes, Explain:_____

Have any family members been in counseling or treatment for mental illness or substance abuse?

_____

Additional Notes:_____

_____

_____

_____

Victimization/Abuse:

Physical Abuse?___No ___Yes:_____

Emotional Abuse?___No ___Yes:_____

Sexual Abuse?___No ___Yes:_____

DRUG AND ALCOHOL

History: (date/age of first use, date/age of last use, heaviest use, frequency, tolerance, method of ingestion, etc.)

Alcohol ___No ___Yes:_____

Marijuana ___No ___Yes:_____

Mushrooms ___No ___Yes:_____

Acid ___No ___Yes:_____

Methamphetamine ___No ___Yes:_____

Cocaine ___No ___Yes:_____

Pills ___No ___Yes:_____

Heroine ___No ___Yes:_____

Inhalants (huffing) ___No ___Yes:_____

Cigarettes ___No ___Yes:_____

Other:_____

Drug of choice:_____

Have you ever been under the influence of drugs or alcohol while at school?___No ___Yes

Have you ever (unsuccessfully) attempted to quit using drugs or alcohol before?___No ___Yes:__

Has anything bad ever happened to you because of your drug or alcohol use? (school, home, legal, friends, work)___No ___Yes:_____

Have you ever done a "wake and bake"?___No ___Yes

Have you ever combined drugs in order to enhance an effect? (stacking) ___No ___Yes

Have you ever used one drug to counteract the effects of another drug? (morphing) ___No ___Yes

Have you ever been in drug and alcohol treatment or received an assessment?___No ___Yes:____

_____

_____

Family Substance Abuse:

Mother: ___No ___Yes, Substance(s):_____

Father: ___No ___Yes, Substance(s):_____

Siblings: ___No ___Yes, Substance(s):_____

Relatives: ___No ___Yes, Substance(s):_____

Additional Notes:_____

_____

_____

_____

SAFETY

Are any weapons available in the home, or does youth have access to weapons?___No ___Yes:___

_____

Does youth have preoccupation with or use of weapons?___No ___Yes:_____

Any history of fire setting?___No ___Yes:_____

Any history of animal abuse?___No ___Yes:_____

Any concerns about anger management or impulsivity?_____

REPAIRING HARM

Who was hurt by your actions?_____

_____

What have you already done to make up for your actions?_____

_____

Is there anything else you could do?_____

_____

What can you do to show people you will make better choices in the future?_____

_____

GOALS

What are some of your short-term goals? (within the next month)_____

_____

What are some of your long-term goals? (within the next year)_____

_____

What are some goals you would like to work on with me?_____

How can I help you achieve these goals?_____

Additional Notes:_____

SHORT TERM COMPETENCY DEVELOPMENT/SKILL BUILDING AREAS

PLANNING/GOALS

1. **POSITIVE ADULT:** Is there a positive adult to support the youth with meeting the goals? If not, GOAL:_____

2. **HEALTHY IDENTITY:** Is the youth involved in any positive activities or pursue any positive interests? If not, GOAL:_____

3. **COMMUNITY CONNECTIONS:** Is the youth engaged with any educational/vocational activities or involved in any community groups or resources? If not, GOAL:_____

4. **REPAIRING HARM:** Has the youth taken responsibility for his/her actions; do he/she understand the impact of his/her behavior; has he/she made efforts to repair harm? If not, GOAL:_____