

PATIENT (MINOR) INTAKE FORM

Client Name: _____ Date of Birth : _____

Age: _____ Height: _____ Weight: _____ Racial Background: _____

Homeless (Circle Y or N): Present - Yes/ No Past: Yes/ No Who does minor reside with? _____

Highest Level of Education: _____ Special Education or IEP? If yes, what year? _____

Mother's Pregnancy: Routine Prenatal Care: Yes/ No

Any complications/ Illnesses/Significant Stress During Pregnancy, Labor or Delivery:

Developmental Milestones (crawl, walk, talk, potty training, etc) Delays:

History of trauma/ or abuse (physical, sexual, emotional, psychological):

List any physical/mental symptoms, concerns, and diagnoses:

List any substance abuse treatment or inpatient psychiatric hospitalizations including dates:

Current medications: _____

Legal History (Arrest, convictions, dates, location) :

Please indicate whether or not you have in the past or currently experience the following symptoms:

Substance Use	Past Use	Current Use	Amount/ Frequency
Cigarettes			
Alcohol			
Marijuana			
Cocaine or crack			
Methamphetamine			
Pills not prescribed to me			
Other Drugs/ Substances			

Is the minor able to complete the following daily activities, if applicable (Circle Y/N):

Driving ... Y/N

Prepare & cook meals using microwave/ stove ...Y/N

Dress by themselves ...Y/N

Shower/ Bathe, Brush Teeth ...Y/N

Household chores (vacuuming, mopping, organizing, feeding pets) ...Y/N

Manage their finances (checking/savings accounts, pay bills, make change)... Y/N

Please check the following concerns. Leave blank if it does not apply:

	Past	Current		Past	Current
Difficulty falling or staying asleep			Issues with memory		
Sleeping too much			Hyperactive/ Impulsive		
Change in appetite, unintentional weight loss or gain			Inattentive		
Vomiting to lose weight			Startle easily		
Using laxatives or exercise excessively			Memories of past upsetting events		
Periods of daily sadness lasting more than 2 weeks			Difficulty controlling temper		
Frequent crying/ tearfulness			Excessive, uncontrollable worry		
Panic attacks			Little/ No interest in sex		
Anxiety			Withdrawing from others		
Thoughts of self harm			Increased irritability		
Thoughts of harming others			Elevated mood/ excessive energy all days for at least 1 week		
Difficulty with concentration or attention			Hearing/seeing/tasting/ smelling things that others do not		
Feeling checked out of reality			Odd beliefs, desires, or behaviors		

Other Concerns:
