THREEFOLD CLINICAL CARE

YOUTH INTAKE QUESTIONNAIRE

Youth's name:		DOB:		Age:	
Gender:		Race/ethnicity/ancestry:			
Grade:		School:			
Form completed by:	Parent ☐	Guardian ☐	Other:		
Reason for seeking services (motivation, need, problem, symptoms, issues, concerns):					
How long has the youth had these needs, symptoms, or issues?					
Has the youth had treatment for these issues in the past?			Yes ☐	No ☐	
Has the youth received inpatient mental health treatment?			Yes ☐	No ☐	
Briefly describe the youth's history of mental health treatment (dates and name of facility/therapist):					
Has the youth had treatment for substance use?			Yes ☐	No ☐	
Briefly describe substance use treatment history (dates, name of facility/therapist, substance concern):					
Does the youth's family have a history of mental health concerns or substance use? If so, please describe:					
Describe the impact of the youth's current emotional or behavioral struggles on family, school, and social life:					

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Describe the youth's strengths and unique qualities:

Is the youth currently under the care of a physician or psychiatrist? If yes, please provide the following:	
Doctor's name:	
Address:	
Phone:	
Treatment for:	
Medications:	

Has the youth ever experienced an upsetting event or situation? (abuse, neglect, abandonment, bullying, loss of a loved one or pet, moving, surgery, pain). Please briefly describe below, including dates, location, alleged perpetrators (as indicated), type of abuse (as indicated), and observed impact of experience on the youth:

Is there any legal action pending related to accusations of abuse or neglect?	Yes ☐	No ☐

History of Legal Involvement					
Legal involvement	Current	Past	Legal involvement	Current	Past
Custody	☐	☐	Visitation	☐	☐
Adoption	☐	☐	Child Protective Services (DCPP)	☐	☐
Probation	☐	☐	Other:	☐	☐

Please provide contact information (name, title, phone number) for all legal persons currently involved with the youth's care:

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Family Stressors					
Stressor	Current	Past	Stressor	Current	Past
Marital struggles	☐	☐	Housing problems	☐	☐
Marital separation	☐	☐	Legal issues	☐	☐
Divorce	☐	☐	Death of a friend	☐	☐
Custody disputes	☐	☐	Death of a relative	☐	☐
Financial problems	☐	☐	Death of a pet	☐	☐
Job loss	☐	☐	Family illness	☐	☐
Parent using alcohol/drugs	☐	☐			
Additional stressors not listed above:					
Please describe the current youth custody agreement:					
Symptom Checklist					
Symptom	Current	Past	Symptom	Current	Past
Crying, sadness, depression	☐	☐	Temper outbursts, aggression	☐	☐
Loss of enjoyment in usual activities	☐	☐	Irritability, anger	☐	☐
Desire to die	☐	☐	Argues frequently	☐	☐
Easily distracted	☐	☐	Disobedience	☐	☐
Made suicidal gestures/attempts	☐	☐	Hallucinations	☐	☐
Worries more than others	☐	☐	Unusual fears or phobias	☐	☐
Panics	☐	☐	Anxious, nervous	☐	☐
Repeats unnecessary acts	☐	☐	Is overly concerned	☐	☐
Exhibits rituals, habits, superstitions	☐	☐	Twitches, unusual movements	☐	☐
Easts very little/fasts to lose weight	☐	☐	Gorges or binge eats	☐	☐
Sleep walking	☐	☐	Blames others for own mistakes	☐	☐
Withdrawn	☐	☐	Easily annoyed by others	☐	☐
Nightmares, night terrors	☐	☐	Low motivation	☐	☐
Low self-esteem	☐	☐	Disorientation	☐	☐
Wakes up very early	☐	☐	Vomits intentionally	☐	☐
Tiredness, fatigue	☐	☐	Injures self intentionally	☐	☐
Restless sleep, wakes frequently	☐	☐	Struggles with friendships	☐	☐
Trouble falling asleep	☐	☐	Feels shy around others	☐	☐
Excessive sleep	☐	☐	Grief or loss	☐	☐
Poor appetite	☐	☐	Feelings of worthlessness	☐	☐
Under or over weight	☐	☐	Chronic pain	☐	☐
Hyperactivity	☐	☐	Drug use	☐	☐
Frequently acts without thinking	☐	☐	Alcohol use	☐	☐
Does not complete tasks	☐	☐	Cigarette use	☐	☐
Headaches	☐	☐	Sexual problems	☐	☐
Easily distracted	☐	☐	Mood swings	☐	☐
Academic struggles	☐	☐	Ideas of harming others	☐	☐
Worries about money	☐	☐	Disorganized thoughts	☐	☐
Concerned about family members	☐	☐	Problems at work	☐	☐
Relationship problems	☐	☐	Feelings of hopelessness	☐	☐
Daydreams, fantasizes	☐	☐	Problems with the law	☐	☐
Additional symptoms not listed above:					

Developmental History					
During pregnancy, did the youth's biological mother:					
	Yes	No		Yes	No
Drink alcohol	☐	☐	Experience pregnancy complications	☐	☐
Use legal substances	☐	☐	Experience problems during labor	☐	☐
Use illegal substances	☐	☐	Experience problems during delivery	☐	☐
Take medications	☐	☐	Experience a physical accident	☐	☐
Become ill	☐	☐	Additional:		

Please check if the youth experienced any of the following:					
	Yes	No		Yes	No
Delays in holding up head	☐	☐	Delays in toilet training	☐	☐
Delays in turning over	☐	☐	Delays in using single words	☐	☐
Delays in sitting up	☐	☐	Delays in using sentences	☐	☐
Delays in Crawling	☐	☐	Delays in dressing self	☐	☐
Delays in walking alone	☐	☐	Delays in sleeping through the night	☐	☐
Delays in Weaning	☐	☐	Delays in feeding self	☐	☐
Ate well	☐	☐	Was clumsy	☐	☐
Was colicky	☐	☐	Was easy to regulate, sleeping/eating	☐	☐
Exhibited head banging behavior	☐	☐	Wanted to be left alone	☐	☐
Was adaptable to transitions	☐	☐	Easy to soothe	☐	☐
Was more interested in things than people	☐	☐	Performed daredevil behavior	☐	☐
Additional:					

Rewards and Consequences Used with the Youth			
Time out	☐	Extra chores	☐
Loss of privileges	☐	Rewards/incentives	☐
Grounding	☐	Physical/corporal punishment	☐
Additional:			

Relationship Development					
Please check all that apply to the youth:					
Behavior	Current	Past	Behavior	Current	Past
Prefers to be alone	☐	☐	Is demanding and bossy	☐	☐
Is frequently alone and feels lonely	☐	☐	Fights with others	☐	☐
Is shy	☐	☐	Bullies others	☐	☐
Has few friends	☐	☐	Teases other youth	☐	☐
Has many friends	☐	☐	Prefers to play with younger children	☐	☐
Plays with "problem kids"	☐	☐	Prefers to play with other children	☐	☐
Is bullied and/or "picked-on"	☐	☐	Poor relationships with peers	☐	☐
Is oversensitive	☐	☐	Conflict with parents/guardians	☐	☐
Has poor relationships with teachers	☐	☐	Has difficulty with siblings	☐	☐
Additional:					

School					
Please check all that apply to the youth:					
The youth…	Current	Past	The youth…	Current	Past
Dislikes school	☐	☐	Missed many school days	☐	☐
Works hard but does not do well	☐	☐	Repeated a grade	☐	☐
Unmotivated, refuses to complete work	☐	☐	Is disciplined frequently, receives detentions	☐	☐
Has learning struggles	☐	☐	Is disruptive in class	☐	☐
Has been expelled from school. If yes, how many times? _____	☐	☐	Has been suspended. If yes, how many times? _____	☐	☐
Is in resource classes/special edu.	☐	☐	Is in a vocational school	☐	☐
Is in the gifted and talented program	☐	☐	Is in an out-of-district placement	☐	☐
Receives speech therapy services	☐	☐	Receives home-bound education	☐	☐
Meets with the school counselor	☐	☐	Has an IEP or 504 Plan	☐	☐
Please provide any additional information as needed:					

Medical History				
Condition	Yes	No	Age	Details
Serious infection	☐	☐		
Convulsions/seizures	☐	☐		
Head injury	☐	☐		
Other injuries	☐	☐		
Medical hospitalizations	☐	☐		
Surgeries	☐	☐		
Poisoning	☐	☐		
Allergies	☐	☐		
Asthma	☐	☐		
Complications from alcoholism	☐	☐		
Complications from drug use	☐	☐		
Unexplained aches and pains	☐	☐		
Other:				
Other:				
Other:				

Family Information			
List all of the people who currently live with the youth			
Name	Age	Relationship	Occupation/grade in school
Who are the youth's supports? (family, friends, faith, clubs, etc.):			

What are the youth's goals for treatment?

_____

Client (print) Signature Date

_____

Parent/Guardian (print) Signature Date

_____

Provider (print) Signature Date