



## Behavioral Health Child/Adolescent Intake Form

<b>Child Name (First, MI, Last)</b>		<b>Age</b>	<b>Date of Birth</b>
<b>School</b>		<b>Grade</b>	<b>Today's Date</b>
<b>Primary M.D.</b>	<b>Social Worker</b>		<b>County</b>
<b>Who Referred You?</b>			
<b>What are the current concerns? List in order of importance.</b>			
1. _____			
_____			
2. _____			
_____			
3. _____			
_____			
<b>Mental Health Treatment History</b>		<b>Place(s) and Date(s)</b>	
Psychiatric Consultation			
Outpatient Therapy/Counseling			
Inpatient Hospitalization			
Partial Hospitalization (Hospital-Based)			
Day Treatment (Alternative School or School-Based)			
Chemical Dependency Treatment			
In-home Family Therapy			
Psychological testing (IEP, IQ, achievement, etc.)			
Are there other ways that your family has attempted to deal with the concerns?		No	Yes describe below
1.			
2.			
3.			

**SYMPTOM CHECKLIST:** Read each item below and decide how much you think your child/adolescent has been showing the problem during the past month. (0 = Not at all      1 = Rarely      2 = Sometimes      3 = Often)

**NEURODEVELOPMENTAL SYMPTOMS**

	Fails to give close attention to details or makes careless mistakes in schoolwork, work, or activities
	Has difficulty sustaining attention in tasks or play activities
	Does not seem to be listening when spoken to directly
	Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
	Has a difficult time organizing tasks and activities (e.g. managing sequential tasks, organizing materials, etc.)
	Avoids or dislikes or is reluctant to engage in tasks that require sustained mental effort
	Loses things necessary for tasks or activities
	Is distracted by extraneous stimuli (for adolescents and adults this may include unrelated thoughts)
	Is forgetful in daily activities (e.g., doing chores, running errands, keeping appointments, etc.)
	Fidgets with or taps hands and feet or squirms in seat
	Leaves seat in situations when remaining seated is expected
	Runs about or climbs in situations where it is inappropriate (or feelings of restlessness in adolescents/adults)
	Unable to play or engage in leisure activities quietly
	Is "on the go", acting as if "driven by a motor" (e.g. unable to sit still for extended periods of time)
	Talks excessively
	Blurts out an answer before a question has been completed
	Has difficulty waiting his or her turn
	Interrupts or intrudes on others (e.g. butts into games, conversations or activities, uses others' things)
	Intellectual or cognitive impairment or delays
	Speech or language problems
	Has difficulty in reading (word reading accuracy, reading rate or fluency, reading comprehension)
	Has difficulty in mathematics (number sense, memorization of math facts, accuracy or fluency, reasoning)
	Has difficulty in written expression ( spelling, grammar/punctuation, clarity or organization)
	Motor/coordination problems
	Vocal/motor tics (e.g., repetitive eye blinking, throat clearing, facial movements, noises, etc.)
	Has difficulty with social communication and social interaction across multiple contexts/settings. <b>IF YES, CHECK THOSE BELOW THAT APPLY.</b>
	<input type="checkbox"/> Deficits in social-emotional interactions (e.g. approaching others abnormally, failing to converse back and forth, doesn't share interests or feelings, fails to initiate or respond to social interactions, etc.)
	<input type="checkbox"/> Deficits in nonverbal communication (e.g. abnormal eye contact or body language, lack of facial expression, trouble understanding or using gestures)
	<input type="checkbox"/> Trouble developing or keeping friendships at a level expected for developmental age
	Restricted, repetitive patterns of behavior, interest, use of objects or speech. <b>IF YES, CHECK THOSE BELOW THAT APPLY.</b>
	<input type="checkbox"/> Repetitive patterns of behavior, interests, use of objects, or speech
	<input type="checkbox"/> Repetitive or unusual motor movements, use of objects or speech
	<input type="checkbox"/> Insistence on things being the same, inflexible routines or patterns of verbal/nonverbal behavior
	<input type="checkbox"/> Highly restricted interests that are abnormal in intensity or focus
	<input type="checkbox"/> Under or over-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. indifference to pain/temperature, over response to textures, smells, light, movement, sounds, or tastes)

DISRUPTIVE BEHAVIOR SYMPTOMS	
	Loses temper
	Touchy and easily annoyed
	Angry and resentful
	Argues with adults
	Actively defies or refuses to comply with rules or requests from authority figures
	Deliberately annoys others
	Blames others for own mistakes or misbehavior
	Spiteful or vindictive
	Behavioral outbursts involving verbal or physical aggression
	Bullies, threatens or intimidates others
	Initiates physical fights
	Used a weapon that can cause serious physical harm to others
	Physically cruel to people or animals
	Has stolen while confronting a victim
	Forced someone into sexual activity
	Deliberately engaged in fire setting with the intention of causing damage
	Deliberately destroyed others' property
	Broke into someone's house, building, or car
	Lies in order to obtain favors or to avoid obligations
	Has stolen without confrontation (e.g., forgery, shoplifting)
	Stays out at night without permission
	Has run away from home overnight
	Has been truant
	Verbal aggression or physical aggression toward property, animals, or other individuals, not resulting in physical injury to animals or other individuals.
	Behavioral outbursts involving damage or destruction of property and/or physical assault involving injury against animals or other individuals within a 12-month period.
MOOD SYMPTOMS	
	Temper outbursts manifested verbally and/or behaviorally, that are out of proportion to the situation and are inconsistent with developmental level
	The mood in between temper outbursts is persistently irritable or angry
	Depressed or irritable mood
	Less interest or pleasure in all or almost all activities
	Significant weight loss when not dieting or weight gain (greater than 5% of body weight in a month)
	Difficulty sleeping or oversleeping
	Increased movement and agitation or decreased movement and slowing down
	Fatigue or loss of energy
	Feelings of worthlessness or excessive and inappropriate guilt
	Difficulty thinking or concentrating, or indecisiveness
	Thoughts of death, or suicidal thoughts (with or without a specific plan), or suicide attempt(s)
	Has had a <i>distinct</i> period of abnormally and persistently elevated (happy, excited) or irritable mood <i>and</i> abnormally and persistently increased goal-directed activity or energy. <b>IF YES, CHECK THOSE BELOW THAT APPLY.</b>
	<input type="checkbox"/> At least 4 days of noticeably increased, inflated self-esteem or grandiosity
	<input type="checkbox"/> At least 4 days of noticeably decreased need for sleep (e.g. feels rested on 3 hours of sleep)
	<input type="checkbox"/> At least 4 days of noticeably increased talkativeness or pressure to keep talking
	<input type="checkbox"/> At least 4 days of noticeably increased racing thoughts or flight of ideas
	<input type="checkbox"/> At least 4 days of noticeably increased distractibility
	<input type="checkbox"/> At least 4 days of noticeably increased goal-directed activity or motor agitation (purposeless activity)

<input type="checkbox"/>	At least 4 days of noticeably excessive involvement in high risk activities
<b>ANXIETY SYMPTOMS</b>	
	Fear and anxiety concerning separation from home or major attachment figures
	Failure to speak in certain social situations (e.g., school or with unfamiliar adults) but speaking ok at home
	Marked fear/anxiety about a specific object or situation (e.g., heights, animals, the dark)
	Marked fear/anxiety about social situations involving being observed by others (e.g., performing, conversing)
	Panic attacks (sudden onset of intense fear or physical discomfort that reaches a peak within minutes)
	Anxiety and worry about a number of events or activities, occurring more days than not
<b>OBSESSIVE-COMPULSIVE SYMPTOMS</b>	
	Recurrent and persistent thoughts, urges, or images that cause marked anxiety or distress
	Repetitive behaviors (e.g., hand washing, checking) or mental acts (e.g., praying, counting) that the individual feels driven to perform in response to an obsession or according to rules that must be rigidly applied
	Preoccupation with perceived defects or flaws in physical appearance that are not observable to others
	Difficulty discarding or parting with possessions, regardless of their value (i.e., hoarding)
	Hair pulling
	Skin picking
<b>TRAUMA - AND STRESSOR - RELATED SYMPTOMS</b>	
	Has experienced a pattern of extreme, insufficient care (e.g., neglect, deprivation, changes in caregivers, etc.) <b>IF YES, CHECK THOSE THAT APPLY</b>
<input type="checkbox"/>	Rarely or minimally seeks or responds to comfort from caregivers when upset or distressed
<input type="checkbox"/>	Minimal social and emotional responsiveness to others
<input type="checkbox"/>	Limited positive emotions
<input type="checkbox"/>	Episodes of unexplained irritability, sadness or fearfulness during interactions with adult caregivers
<input type="checkbox"/>	Reduced caution in approaching and interacting with unfamiliar adults
<input type="checkbox"/>	A pattern of actively approaching and interacting with unfamiliar adults (e.g., a willingness to go off with unfamiliar adults with little or no hesitation, being overly familiar, not checking back with caregivers after venturing away, etc.)
	Has had exposure to actual or threatened death, serious injury, or sexual violence <b>IF YES, CHECK THOSE THAT APPLY</b>
<input type="checkbox"/>	Recurrent, distressing memories or dreams of the traumatic event
<input type="checkbox"/>	Re-enactment of the traumatic event in repetitive play activities
<input type="checkbox"/>	Intense, physical or emotional distress when exposed to reminders of the traumatic event
<input type="checkbox"/>	Flashbacks of the traumatic event (i.e., feeling or acting as if the traumatic events were recurring)
<input type="checkbox"/>	Persistent avoidance of memories, thoughts, feelings, places or objects associated with the traumatic event
<input type="checkbox"/>	Negative changes in thoughts or mood beginning or worsening after the traumatic event (e.g., guilt, shame, loss of interest, feeling detached, self-blame, etc)
<input type="checkbox"/>	Marked changes in arousal or reactivity, beginning or worsening after the traumatic event (e.g. angry outbursts, hypervigilance, problems sleeping, reckless/destructive behavior, etc.)
<b>DISTORTED THINKING OR PERCEPTION SYMPTOMS</b>	
	Delusions (i.e., persistent odd or false beliefs)
	Hallucinations (i.e., hearing or seeing things that are not really there)
<b>DISORDERED EATING SYMPTOMS</b>	
	Episodes of binge eating
	Inappropriate behaviors used to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives or diuretics, fasting, excessive exercise, etc.)

Restriction of food intake leading to significantly low body weight (i.e., less than minimally expected)
Fear of gaining weight or becoming fat
Disturbance in the way in which one's body weight or shape is experienced

**GENDER DYSPHORIA SYMPTOMS**

Incongruence between one's experienced/expressed gender and actual gender, of at least 6 months duration

**MISCELLANEOUS SYMPTOMS**

Are there other symptoms or concerns that you have about this child/adolescent? If yes, please describe :

**Risk Indicators (Check all that apply)**

Wish to be Dead: has had thoughts about a wish to be dead or not live anymore, or a wish to fall asleep and not wake up.
Suicidal Thoughts: has had non-specific thoughts of wanting to end life/die by suicide.
Suicide Behavior: has had an actual suicide attempt, an interrupted attempt, or other preparatory acts to kills self
Self-injurious behavior <i>without</i> suicidal intent
Method for suicide available (gun, pills, etc.)
<input type="checkbox"/> No firearms in the home <input type="checkbox"/> Firearms are easily accessed <input type="checkbox"/> Use of safe firearm and ammunition storage practices
Family history of suicide (lifetime)
Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
Arrests/Pending incarceration
Current or pending isolation or feeling alone
Hopelessness
Command hallucinations to hurt self
Highly impulsive behavior
Drug or alcohol abuse/dependence
Perceived burden on family or others
Chronic physical pain or other acute medical problem
Homicidal thoughts/preoccupation with violence
Aggressive behavior toward others
Sexual abuse (lifetime)
Unhealthy peer group
Inappropriate sexual activity

**Current Living Situation**

<b>Parent's name:</b>	Age:	<input type="checkbox"/> Biological	<input type="checkbox"/> Adoptive	<input type="checkbox"/> Step
Address:	City:	State:		
Lives with the child/adolescent? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, where does he/she live?			
Employed outside of the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation:	Hours/wk:		
<b>Parent's name:</b>	Age:	<input type="checkbox"/> Biological	<input type="checkbox"/> Adoptive	<input type="checkbox"/> Step
Address:	City:	State:		
Lives with the child/adolescent? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, where does he/she live?			
Employed outside of the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation:	Hours/wk:		
<b>Parents' marital status:</b> <input type="checkbox"/> never married. <input type="checkbox"/> married for ____ years. <input type="checkbox"/> separated. <input type="checkbox"/> divorced.				
If parents are divorced, describe physical and legal custody?				
<b>Other parent(s) or caregiver(s) names (if different from above):</b>				
Relationship to patient:				

Relationship to patient:

Is the caregiver employed outside the home?  Yes  No

Occupation:

Hours/wk:

**Legal guardian of patient, if other than biological parent(s):**

List all people this child/adolescent is presently living with:

Name	Age	Relation	Health Status:

List any immediate family members who do not live with this child/adolescent and any deceased family members:

Name	Living	Age	Relation	City, State

**Developmental History**

**Prenatal and Delivery History**

How was the mother's overall health during pregnancy with this patient?:  good  fair  poor  don't know

Did the mother experience any medical problems or complications during pregnancy?  Yes  No  
If yes, please specify:

How old **were** the parents when this patient was born? Mother \_\_\_\_\_ Father \_\_\_\_\_

What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?

Alcohol: Describe amount and frequency. \_\_\_\_\_

Tobacco: Describe amount and frequency. \_\_\_\_\_

Street Drugs: Describe what drugs, amount and frequency. \_\_\_\_\_

Prescription Drugs: Describe what drugs, amount and frequency. \_\_\_\_\_

Was this child/adolescent born:  less than 30 weeks gestation  30-35 weeks  36-40 weeks  over 40 weeks

Was delivery:  Normal  Breech  Caesarian  Forceps/vacuum assisted  Induced

What was the child/adolescent's birth weight? \_\_\_\_\_

Were there indications of fetal distress during labor/birth? Yes No

If yes, please specify \_\_\_\_\_

Were there any health complications following birth? Yes No

If yes, please specify \_\_\_\_\_

### Postnatal Period and Infancy

Were there any infancy feeding problems? Yes No

If yes, please specify \_\_\_\_\_

Was this child/adolescent colicky as an infant? Yes No

If yes, please specify \_\_\_\_\_

Were there infancy sleep pattern difficulties? Yes No

If yes, please specify \_\_\_\_\_

Were there problems with responsiveness/alertness during infancy? Yes No

If yes, please specify \_\_\_\_\_

How easy was this child/adolescent as a baby?

Very easy      Easy      Average      Difficult      Very Difficult

Were there any concerns about this child/adolescent's attachment to the primary caregiver(s)? Yes No

If Yes, please specify \_\_\_\_\_

### Toddler Period

As an infant/toddler, how did this child/adolescent behave with other people?

More sociable than average     Average sociability     Actively avoided socializing     More shy than average

As an infant/toddler, how insistent was this child/adolescent when he or she wanted something ?

Very insistent     Somewhat insistent     Average     Passive

As an infant/toddler, how active was this child/adolescent?

Very active     Active     Average     Less active     Very inactive

How would you describe this child's play as an infant/toddler? (Check all that apply)

Loud     Interested in playing with others     Imaginative / Make believe

Quiet     Played alone     Repetitive     Rigid, concrete

### Developmental Milestones

Have you or anyone else ever had concerns about this child/adolescent's development?  Yes  No

If yes, please specify \_\_\_\_\_

At what age (in months) did this child/adolescent:

Sit up? \_\_\_\_\_ Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_

At what age (in months) did this child/adolescent speak single words (other than "Mama" or "Dada")? \_\_\_\_\_

At what age (in months) did this child/adolescent begin stringing two or more words together? \_\_\_\_\_

At what age (in months) was this child toilet trained? For bladder \_\_\_\_\_ For bowel \_\_\_\_\_

### Medical History

How would you describe your child/adolescent's health?

Very Good     Good     Fair     Poor     Very Poor

How is his/her hearing?  Good     Fair     Poor    Fine motor coordination?  Good     Fair     Poor

Vision?  Good     Fair     Poor    Gross motor coordination?  Good     Fair     Poor

Speech and language?  Good     Fair     Poor

Has this child/adolescent ever had chronic health problems (e.g., asthma, diabetes, allergies, heart condition)?  Yes  No

If yes, please specify \_\_\_\_\_

Which of the following illnesses has this child/adolescent had? Check all that apply:

Chronic diarrhea     Stomach aches     High fevers     Chronic pain     Chronic ear infections  
 Constipation     Allergies     Encephalitis     Chronic headaches     Lead poisoning  
 Asthma     Croup     RSV     Chicken pox     Urinary tract infections  
 Pneumonia     Seizures     Meningitis     Other \_\_\_\_\_

Has this child/adolescent had any medical problems aside from the usual childhood illnesses? Yes No

If yes, please specify \_\_\_\_\_  
\_\_\_\_\_

Has this child/adolescent ever been hospitalized? Yes No

If yes, please specify the reason, date, outcome and name of hospital. \_\_\_\_\_  
\_\_\_\_\_

Has this child/adolescent ever had any emergency room visits for emotional or behavioral problems? Yes No

If yes, please specify the reason, date, outcome and name of hospital. \_\_\_\_\_  
\_\_\_\_\_

Has this child/adolescent ever received medication for emotional, physical, learning or behavioral problems? Yes No

If yes, please specify:

**Medication #1:** \_\_\_\_\_

Reason prescribed? \_\_\_\_\_

Daily Dose: \_\_\_\_\_

Who Prescribed This?: \_\_\_\_\_

How long was this taken?: \_\_\_\_\_

Was this helpful? \_\_\_\_\_

Side effects: \_\_\_\_\_

**Medication #2:** \_\_\_\_\_

Reason prescribed? \_\_\_\_\_

Daily Dose: \_\_\_\_\_

Who Prescribed This? \_\_\_\_\_

How long was this taken? \_\_\_\_\_

Was this helpful? \_\_\_\_\_

Side effects: \_\_\_\_\_

**Medication #3:** \_\_\_\_\_

Reason prescribed? \_\_\_\_\_

Daily Dose: \_\_\_\_\_

Who Prescribed This? \_\_\_\_\_

How long was this taken? \_\_\_\_\_

Was this helpful? \_\_\_\_\_

Side effects: \_\_\_\_\_

**Medication #4:** \_\_\_\_\_

Reason prescribed? \_\_\_\_\_

Daily Dose: \_\_\_\_\_

Who Prescribed This? \_\_\_\_\_

How long was this taken? \_\_\_\_\_

Was this helpful? \_\_\_\_\_

Side effects: \_\_\_\_\_

**Medication #5:** \_\_\_\_\_

Reason prescribed? \_\_\_\_\_

Daily Dose: \_\_\_\_\_

Who Prescribed This? \_\_\_\_\_

How long was this taken? \_\_\_\_\_

Was this helpful? \_\_\_\_\_

Side effects: \_\_\_\_\_

**Medication #6:** \_\_\_\_\_

Reason prescribed? \_\_\_\_\_

Daily Dose: \_\_\_\_\_

Who Prescribed This? \_\_\_\_\_

How long was this taken? \_\_\_\_\_

Was this helpful? \_\_\_\_\_

Side effects: \_\_\_\_\_

Has this child/adolescent had any accidents resulting in the following? (Check all that apply)

- Sutures      Broken bones      Severe lacerations      Head injury  
Severe bruises      Loss of teeth      Loss of consciousness      Eye injury

Please explain the injury: \_\_\_\_\_  
\_\_\_\_\_

Does this child/adolescent have any bladder control problems?:  No  Yes  
 If yes, are these ...  During the day?  During the night?

Does this child/adolescent have any bowel control problems?:  No  Yes  
 If yes, are these ...  During the day?  During the night?

This child/adolescent's usual bedtime is at: \_\_\_\_\_ when in school. \_\_\_\_\_ when on vacation.

Describe this child/adolescent's sleep patterns or habits:  
 Sleeps all night without disturbance  Has trouble falling asleep  TV in bedroom  Early morning awakening  
 Awakens during night/restless sleeper  Screen time up to bedtime  Severe snoring  Sleeps outside bedroom  
 Gets out of bed in middle of the night  Sleeps with parent(s)

Describe this child/adolescent's eating habits:  
 Overeats  Average  Under eats  Binge eating  Intentionally restricts intake

**Family Health History**

	Mother	Father	Sibling	Describe the disability or health problem
Family member disability?				
Family member serious health problems?				

**Family Mental Health History**

Check all that apply to biological family	Mother	Maternal family	Father	Paternal family	Siblings
Heart Problems					
Thyroid Problems					
Problems with inattention, hyperactivity/ impulse control.					
Problems with aggression, oppositional, or antisocial behavior as a child.					
Learning disabilities					

Cognitive/intellectual disabilities					
Autism Spectrum					
Anxiety					
Depression					
Obsessive Compulsive Disorder					
Eating Disorder					
Schizophrenia or Psychosis					
Bipolar Disorder					
Suicidal thoughts or attempts					
Drug abuse or dependence					
Victim of sexual abuse					
Victim of physical abuse					
Other: (specify)					

**Cultural, Spiritual Influences**

Describe any important spiritual/religious/cultural influences that are important in understanding this child/adolescent's problems or treatment: \_\_\_\_\_

**Life Stressors/Trauma History**

Has this child/adolescent experienced or witnessed any of the following? (Check all that apply)

- Domestic violence/abuse: Explain \_\_\_\_\_
- Community violence: Explain \_\_\_\_\_
- Physical abuse: Explain \_\_\_\_\_
- Verbal or Emotional abuse: Explain \_\_\_\_\_
- Sexual assault/molestation: Explain \_\_\_\_\_

- Physical neglect: Explain \_\_\_\_\_
- Serious illness: Explain \_\_\_\_\_
- Serious accident : Explain \_\_\_\_\_
- Divorce/Separation/Remarriage of Parent: Explain \_\_\_\_\_
- Change of residence: Explain \_\_\_\_\_
- Change of schools: Explain \_\_\_\_\_
- Job changes of parents: Explain \_\_\_\_\_
- Pregnancy/Miscarriage/Abortion: Explain \_\_\_\_\_
- Family chemical abuse: Explain \_\_\_\_\_
- Exposure to drug activity (outside of the home): Explain \_\_\_\_\_
- Foster care or other out-of-home placement: Explain \_\_\_\_\_
- Arrests/Imprisonments in family: Explain \_\_\_\_\_
- Death/loss of family member: Explain \_\_\_\_\_
- Death/loss of friend: Explain \_\_\_\_\_
- Family accident or illness: Explain \_\_\_\_\_
- Financial changes or stressors: Explain \_\_\_\_\_
- Parent conflicts in disciplining: Explain \_\_\_\_\_
- Other: Explain \_\_\_\_\_

### Strengths and Quality of Social Network

What are this child/adolescent's strengths?

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

What does this child/adolescent like to do?

Activities: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Describe this child/adolescent's relationship with each parent:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Step mother: \_\_\_\_\_

Step father: \_\_\_\_\_

Other caregivers: \_\_\_\_\_

Describe this child/adolescent's relationship with siblings:

\_\_\_\_\_

\_\_\_\_\_

Describe this child/adolescent's relationship with peers:

\_\_\_\_\_

\_\_\_\_\_

Describe the parent relationship and any impact on this child/adolescent:

### Educational History

Does your child/adolescent have an IEP for special education services?  No  Yes

If no, has your child ever been tested and determined not to need services?  No  Yes

Please summarize your child/adolescent's academic, behavioral and emotional progress within each of these grade levels. Please include any teacher observations.

Grade	Progress	School/Program
Preschool/ Daycare		
Kindergarten		
1 <sup>st</sup> grade		
2 <sup>nd</sup> grade		
3 <sup>rd</sup> grade		
4 <sup>th</sup> grade		
5 <sup>th</sup> grade		
6 <sup>th</sup> grade		
7 <sup>th</sup> grade		
8 <sup>th</sup> grade		
9 <sup>th</sup> grade		
10 <sup>th</sup> grade		
11 <sup>th</sup> grade		
12 <sup>th</sup> grade		

Has this child/adolescent repeated any grades?  Yes  No

If yes, please specify which grade and why: \_\_\_\_\_  
 \_\_\_\_\_

Has this child/adolescent participated in any special education or other programming? If so, indicate which grade(s)

Program	Grade(s)	Program	Grade(s)
Early Childhood Spec. Ed./Developmental Delay	_____	Developmental/Cognitive Disability	_____
Special Learning Disability	_____	Autism Spectrum Disorder	_____

What are this child/adolescent's strengths in school? \_\_\_\_\_

What are this child/adolescent's weaknesses in school? \_\_\_\_\_

Is the school doing a good job of meeting your child/adolescent's needs? \_\_\_\_\_

Is your child/adolescent currently employed? If yes, where and how many hours/week? \_\_\_\_\_

### Alcohol / Substance Use

Does your child or adolescent drink alcohol?  Yes  No

Has your child or adolescent ever experimented with drugs?  Yes  No

**If you responded “no” to both questions, you can STOP here. Thank you for providing us with this important information.**

**If you responded “yes” to one or both questions, please complete the remaining questions:**

#### **CAGE-AID Questions (to be completed by a child/adolescent age 12 and up)**

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Which category of mood-altering substances has your child/adolescent used?

Alcohol  Prescription drugs  Street drugs  Over-the-counter drugs  None known

Please name all mood-altering substances this child/adolescent has used:

How many years altogether has this child /adolescent been drinking and/or using drugs? \_\_\_\_\_

How would you describe this child/adolescent’s pattern of alcohol or chemical use”?

Continuous and progressive  On and off with no pattern  A fairly regular pattern  Decreasing but more destructive

Has this child/adolescent shown signs of significant mood changes?  Yes  No

If yes, please explain:

The following is a list of common symptoms in individuals who are abusing alcohol or drugs. Please check all that apply.

- Blackouts. How often: \_\_\_\_\_
- Minimizes the extent of their use. Describe: \_\_\_\_\_
- Lies about where they go or who they are with. When did this start? \_\_\_\_\_
- Engages in abusive or aggressive behavior. Describe: \_\_\_\_\_
- Uses mood altering drugs/medications when drinking or substitutes medications for alcohol?
- Stops drinking for periods of time. How often and why? \_\_\_\_\_
- There have been changes in this child/adolescent's drinking pattern. Describe: \_\_\_\_\_  
\_\_\_\_\_
- This child/adolescent's drinking and/or chemical use has resulted in changes in family activities. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Unreasonable resentments. Describe: \_\_\_\_\_  
\_\_\_\_\_

- Changes in sexual drive or activity. Describe: \_\_\_\_\_
- Binges or benders. Describe: \_\_\_\_\_
- Tremors or alcohol/drug related physical problems. Describe: \_\_\_\_\_
- Narrowed range or lack of interests. Describe: \_\_\_\_\_
- Changes in the type of friends or attitudes toward friends. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Left or threatened to leave home after being confronted about chemical use. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Was told by a physician that chemical use is injuring his/her health. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Family members have complained that this child/adolescent spends too much money on alcohol or other chemicals. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Has quit or been threatened with expulsion or suspension from school due to chemical use. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Has been picked up/arrested by police for intoxication or other chemical use related charges. Describe: \_\_\_\_\_  
\_\_\_\_\_
- Has had accidents/injuries related to drinking or chemical use. When/Describe: \_\_\_\_\_  
\_\_\_\_\_
- Has had illnesses related to drinking or chemical use. When/Describe: \_\_\_\_\_  
\_\_\_\_\_
- Has been gone from home without notifying parent(s). When/Describe: \_\_\_\_\_  
\_\_\_\_\_
- Has had other negative consequences related to drinking or substance use. Describe: \_\_\_\_\_  
\_\_\_\_\_

We/I feel responsible for this child/adolescent's drinking/chemical use?  Yes  No

We/I sometimes feel guilty about this child/adolescent's drinking/chemical use?  Yes  No

We/I feel this child/adolescent could quit drinking/using if he/she wanted to badly enough?  Yes  No

This child/adolescent simply lacks the will power to quit drinking/using?  Yes  No

Alcoholism is not a disease so much as it is a sin and moral problem?  Yes  No

We/I feel that this child/adolescent isn't alcoholic or chemically dependent but rather has a drinking/use problem?  Yes  No