

**Adolescent Intake Form**

Parent/Guardian to complete pages 1-9  
 Adolescents aged 13 and older to complete pages 10-17

**General Information:**

Child's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Your Name: \_\_\_\_\_ Relationship to the Child: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone Number (Day): \_\_\_\_\_ Phone Number (Evening): \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_

**Family Information:**

Please list all of the significant parental figures involved in the child's life

Name	Age	Gender	Relationship to the Child	Highest Level of Education	Occupation

**Marital Status of the child's biological parents:**

Single / Married / Divorced / Remarried / Living Together

**If married, date of marriage:** \_\_\_\_\_

**If divorced, date of divorce:** \_\_\_\_\_

If biological parents are divorced, who has legal custody of the child?

Please describe the custody arrangements:

**Number of previous marriages & length for mother:** \_\_\_\_\_

**Number of previous marriages & length for father:** \_\_\_\_\_

Please list all of the child's siblings

Name	Age	Gender	Relationship to the Child	Currently Living in the Home?	Does this child have any behavioral or emotional problems? (Describe)
				YES NO	
				YES NO	
				YES NO	
				YES NO	

### **Developmental History:**

Please list any difficulties that occurred during pregnancy or delivery:

Please describe any concerns related to your child's development:

### **Health:**

Please list all major illnesses, injuries, surgeries, accidents, or other medical conditions that your child has experienced:

Dates	Incident	Treating Physician

Please list all mental health services that your child has received:

Dates	Reason	Therapist/Psychologist

Please list all psychological or psychiatric hospitalizations that your child has been to:

Dates	Reason	Hospital

To your knowledge, has your child ever had any of the following?

Diagnosis or Problem	Yes	No	Person who told you this and their position (eg., 3 <sup>rd</sup> grade teacher, physician). Do not include names.
Aggression	_____	_____	_____
Alternating Mania and Depression (Bipolar)	_____	_____	_____
Anxiety	_____	_____	_____
Attention Deficit Hyperactivity Disorder	_____	_____	_____
Autism	_____	_____	_____
Behavior or Discipline Problems at Home	_____	_____	_____
Behavior or Discipline Problems at School	_____	_____	_____
Conduct Disorder	_____	_____	_____
Depression	_____	_____	_____
Emotional Disturbance	_____	_____	_____
Hospitalized for Emotional Problems	_____	_____	_____
Jail or Probation Due to Problems w/ the Law	_____	_____	_____
Learning Disability or Dyslexia	_____	_____	_____
Learning Problems at School	_____	_____	_____
Mental Retardation	_____	_____	_____
Muscle Twitches or Motor Tics	_____	_____	_____
Nervous Breakdown	_____	_____	_____
Obsessive Thoughts or Compulsive Actions	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____
Problems with Alcohol Use or Abuse	_____	_____	_____
Problems with Drug Use or Abuse	_____	_____	_____
Schizophrenia	_____	_____	_____
Suicide	_____	_____	_____
Tourette's Syndrome	_____	_____	_____
Trouble with the Law	_____	_____	_____
Other Psychological / Behavioral Problems*	_____	_____	_____

Please list any prescription medications that your child is currently taking:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				School days 7 days As needed	
				School days 7 days As needed	
				School days 7 days As needed	
				School days 7 days As needed	

**Please describe your child's medication compliance:**

**Please describe any side effects from the medications:**

## **Education:**

School Name: \_\_\_\_\_

Your child's current grade in school: \_\_\_\_\_ Typical Grades: \_\_\_\_\_

**Has your child ever been held back in school?**

If so, please describe the circumstances:

**Has your child ever been suspended or expelled?**

If so, please describe the circumstances:

**Has your child ever been tested for intellectual ability or had any other psychological testing?**

If so, what was the most recent date of testing:

Please describe the results:

**Does your child have a 504 Plan?**

If so, please describe the nature of the accommodations:

**Does your child receive special education services?**

If so, please describe the nature of the services received:

**Does your child's teacher have concerns about your child?**

If so, please describe:

**Is your child currently participating in a school/classroom intervention?**

If so, please describe:

**Please list any concerns that you have for your child related to school:**

## **Current Reasons for Seeking Treatment:**

Please describe the reasons that you are seeking treatment for your child at this time:

Please briefly describe the history of these concerns and list all factors that may trigger or intensify these concerns:

Please list the things that you have tried/done to help your child:

Please describe your child's strengths:

### Parent DBD Rating Scale

Check the column that best describes this child.

**Please write DK next to any items for which you don't know the answer.**

	Not At All	Just A Little	Pretty Much	Very Much
1. often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the neighborhood)				
21. often shifts from one uncompleted activity to another				

	Not At All	Just A Little	Pretty Much	Very Much
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
24. is often angry and resentful				
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				
34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building, or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others				

**Instructions:** In the spaces below complete the rating at the end of each by marking an "X" on the lines at the points that describe how much your current challenges affect each area and *whether you need treatment or special services for the challenges.*

1a. How your child's challenges affect your relationship with friends.

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

1b. How your child's challenges affect his or her relationship with brothers or sisters (if no siblings, check here \_\_\_\_\_ and skip to #2)

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

2. How your child's challenges affect your relationship with your parent(s).

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

3. How your child's challenges affect your academic progress at school

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

4. How your child's challenges affect your self-esteem

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

5. How your child's challenges affect your family in general

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

6. Overall severity of your child's challenges in functioning and overall need for treatment.

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

**Adolescent Clinical Questionnaire**

(To be completed by the Adolescent Aged 13 and older)

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Please describe the reasons that you are seeking treatment at this time:

Please describe how these concerns have been affecting your relationship with your family:

Please describe how these concerns have been affecting your relationship with your friends:

Please describe how these concerns have been affecting your functioning at school/work:

Please describe the things that you tried that has helped you to feel better:

Please describe the things about yourself that you feel proud of:

### Self-Report DBD Rating Scale

Check the column that best describes you.

**Please write DK next to any items for which you don't know the answer.**

	Not At All	Just A Little	Pretty Much	Very Much
1. often interrupts or intrudes on others (e.g., butts into conversations or games)				
2. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)				
3. often argues with adults				
4. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5. often initiates physical fights with other members of his or her household				
6. has been physically cruel to people				
7. often talks excessively				
8. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)				
9. is often easily distracted by extraneous stimuli				
10. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking				
11. often truant from school, beginning before age 13 years				
12. often fidgets with hands or feet or squirms in seat				
13. is often spiteful or vindictive				
14. often swears or uses obscene language				
15. often blames others for his or her mistakes or misbehavior				
16. has deliberately destroyed others' property (other than by fire setting)				
17. often actively defies or refuses to comply with adults' requests or rules				
18. often does not seem to listen when spoken to directly				
19. often blurts out answers before questions have been completed				
20. often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the neighborhood)				
21. often shifts from one uncompleted activity to another				

	Not At All	Just A Little	Pretty Much	Very Much
22. often has difficulty playing or engaging in leisure activities quietly				
23. often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
24. is often angry and resentful				
25. often leaves seat in classroom or in other situations in which remaining seated is expected				
26. is often touchy or easily annoyed by others				
27. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
28. often loses temper				
29. often has difficulty sustaining attention in tasks or play activities				
30. often has difficulty awaiting turn				
31. has forced someone into sexual activity				
32. often bullies, threatens, or intimidates others				
33. is often "on the go" or often acts as if "driven by a motor"				
34. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35. often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)				
36. has been physically cruel to animals				
37. often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)				
38. often stays out at night despite parental prohibitions, beginning before age 13 years				
39. often deliberately annoys people				
40. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)				
41. has deliberately engaged in fire setting with the intention of causing serious damage				
42. often has difficulty organizing tasks and activities				
43. has broken into someone else's house, building, or car				
44. is often forgetful in daily activities				
45. has used a weapon that can cause serious physical harm to others				

**Instructions:** In the spaces below complete the rating at the end of each by marking an "X" on the lines at the points that describe how much your current challenges affect each area and *whether you need treatment or special services for the challenges.*

1a. How your challenges affect your relationship with friends.

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

1b. How your challenges affect his or her relationship with brothers or sisters  
(if no siblings, check here \_\_\_\_\_ and skip to #2)

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

2. How your challenges affect your relationship with your parent(s).

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

3. How your challenges affect your academic progress at school

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

4. How your challenges affect your self-esteem

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

5. How your challenges affect your family in general

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

6. Overall severity of your challenges in functioning and overall need for treatment.

No Problem	_____	Extreme Problem
Definitely does not need treatment or special services		Definitely needs treatment or special services

Please circle the degree to which you have been experiencing each of the following MOODS, EMOTIONS, and FEELINGS:

	Not At All	To Only A Mild Degree	To a Moderate Degree	To A Very Strong Degree
1. Angry	0	1	2	3
2. Panicky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10. Lonely	0	1	2	3
11. Resentful	0	1	2	3
12. Dependant	0	1	2	3
13. Confused	0	1	2	3
14. Guilty	0	1	2	3
15. Nervous	0	1	2	3
16. Listless	0	1	2	3
17. Hopeless	0	1	2	3
18. Tense	0	1	2	3
19. Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21. Terrified	0	1	2	3
22. Embarrassed	0	1	2	3
23. Elated	0	1	2	3
24. Abandoned	0	1	2	3
25. Agitated	0	1	2	3
26. Worried	0	1	2	3
27. Helpless	0	1	2	3
28. Grief	0	1	2	3

Other Moods, Emotions or Feelings not noted above:

Please circle how often you have been bothered by each of the following difficulties with THINKING:

	Never	Occasionally	Often	Very Often
1. Concentration difficulties	0	1	2	3
2. Difficulty remembering things	0	1	2	3
3. Your mind going "blank"	0	1	2	3
4. Difficulty making decisions	0	1	2	3
5. Difficulty making sound judgments	0	1	2	3
6. Distractible	0	1	2	3
7. Thoughts are "racing"	0	1	2	3
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2	3
9. Repetitive thought(s), image(s), or urge(s)	0	1	2	3
10. Suicidal Thoughts	0	1	2	3
11. Thoughts of Killing Someone	0	1	2	3
12. Preoccupation with Death	0	1	2	3

Other concerns not noted above:

Please circle how much you have been bothered by each of the following PHYSICAL REACTIONS:

	Never	Occasionally	Often	Very Often
1. Shortness of breath or smothering sensations	0	1	2	3
2. Nausea, diarrhea, or other abdominal stresses	0	1	2	3
3. Trouble swallowing or "lump in throat"	0	1	2	3
4. Muscle tension, aches, or soreness	0	1	2	3
5. Flushes (not flashes) or chills	0	1	2	3
6. Dizziness or light-headed	0	1	2	3
7. Trouble falling or staying asleep	0	1	2	3
8. Sweating or cold clammy hands	0	1	2	3
9. Fatigue or loss of energy	0	1	2	3
10. Decrease in appetite	0	1	2	3
11. Weight loss	0	1	2	3
12. Decreased need for sleep	0	1	2	3
13. Numbness or tingling sensations	0	1	2	3
14. Weepiness/crying	0	1	2	3
15. Palpitations or accelerated heart rate	0	1	2	3
16. Headaches	0	1	2	3

	Never	Occasionally	Often	Very Often
17. Increase in appetite	0	1	2	3
18. Weight gain	0	1	2	3
19. Increased need for sleep	0	1	2	3
20. Chest pains or discomfort	0	1	2	3
21. Physical problems (for example, impaired physical functioning, physical pain, etc.)	0	1	2	3
22. Awakening earlier in the morning than you normally do.	0	1	2	3

Other Physical Reactions not noted above:

Please circle how much you have been experiencing each of the following reactions:

	Never	Occasionally	Often	Very Often
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feelings like you want to beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)	0	1	2	3

Please place a checkmark in the appropriate box for each of the following.

Have you ever:	Present	Past	Never
1. Purposely injured yourself without suicidal intent (e.g., cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g., friend, family, partner, or authority figure) with cruel or malicious intent)			

Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours	Used in Last 6 Months
Alcohol					Y N	Y N
Nicotine					Y N	Y N
Marijuana					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N

Over the past 6 months, how many times has each of the following happened to you because of your substance use?

	Never	Once	Twice	3-4 times	5 or more times
1. You've gotten in trouble with your parents					
2. You've had problems at school or with schoolwork					
3. You've had problems with friends					
4. You've had problems with someone you are dating/your partner					
5. You've have been in trouble with the police					