



YOUTH INTAKE ASSESSMENT

Date: ____/____/____

A.) **PERSONAL INFORMATION**

LASTNAME: _____ FIRST NAME _____ M.I. _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

TELEPHONE: () _____ - _____ SCHOOL: _____

DATE OF BIRTH: _____ GRADE: _____

PARENTS/GUARDIAN NAME: _____

B.) **ABOUT YOUR FAMILY:**

1. Who are the people you live with presently?

NAME:

AGE:

RELATIONSHIP TO YOU:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Name any other brothers/sisters who do not live with you.

3. What are some things your family does together?

4. What do your parents hassle you about?

5. What are your responsibilities at home?

6. Can you talk to your family about important things?

7. How do you know your parents love and care for you?

8. How do you show your parents you care for them?

9. How do you express your anger in your family?

10. If you have brothers/sisters, how do you get along with them?

C.) **SCHOOL**

1. What are your favorite subjects?

2. What are your least favorite subjects?

3. What is the best thing about school?

4. What is the worst thing about school?

5. What are any special problems in school now?

6. What are any special problems in school you have had before now?

7. How often do you miss classes?

8. What trouble have you had in school with grades or conduct?

9. What do you do for fun after school?

10. What clubs or groups are you in at school?

11. Have you ever been bullied in school or outside of school? Please explain.

D.) **YOUR FEELINGS:**

1. Are you feeling - Anxious? _____ Angry? _____ Guilty? _____
Afraid? _____ Like you don't care _____ Sad? _____
2. Do you have trouble concentrating? Yes ___ No ___
3. Are you having difficulty sleeping? Yes ___ No ___
4. What is one thing you worry about the most? _____
5. Do you think about suicide or killing yourself? _____ If yes, how often? _____
6. Do you think about killing someone else? _____ If yes, who? _____
7. Have you ever engaged in self-harming behavior (check all that apply)?
Cutting _____ Burning _____ Hitting _____ Other _____

If yes, at what age did you begin, how often, and when was the last time? Describe below.

E.) **SUBSTANCE USE**

1. Do you drink alcohol? _____ How often? _____ How much? _____
When did you begin? _____ If so, what do you drink? _____
2. Do you use drugs? _____ Have you ever used drugs? _____
If so, what drugs have you used (check all that apply)?
Marijuana _____ Heroin _____ Cocaine _____
Amphetamines _____ LSD _____
Over-the-counter drugs (i.e. diet pills, cough syrup, antihistamines, etc.) _____

Any others not listed? _____

When did you begin using drugs? _____

Do you do drugs with others or alone? _____

3. Cigarettes _____ (How many a day?)

F.) **HEALTH**

1. Do you have any special health problems? _____

2. Are you eating more or less than you usually do? _____

3. Do you exercise during the week? If so, what do you do? _____

4. Are you sexually active? Yes__No__If yes, at what age did you first have sex? _____

5. What is your sexual orientation? Heterosexual Gay/Lesbian Bisexual
 Transgendered Not Sure Other_____

6. Do you have any trouble sleeping? Yes__No__If yes, why? _____

7. Do you have trouble staying asleep? Yes__No__If yes, why? _____

8. Do you have trouble falling asleep? Yes__No__If yes, why? _____

9. If you are a female have you started menstruating? If so at what age was your first period/menstrual cycle? _____

10. Have you ever had any nightmares? Please explain.

G.) **YOUR FRIENDS/PERSONAL LIFE**

1. Do you see yourself as a follower or leader? _____

2. Do you have many friends or a few special friends? _____

3. Have you changed friends recently? _____

4. Do your parents hassle you about your friends? _____

5. Who do you like to discuss your problems with? _____

6. Are you currently employed? If so when did you start working and who do you work for?

7. Do you have your driver's license or when will you be getting your driver's license?

H.) **SPIRITUALITY**

1. Have you been raised in any church? What denomination? Do you and/or your parents attend?
2. What are some goals you would like to reach in your life?

I.) **YOUR COUNSELING SESSIONS**

1. What happened that made you and/or your parents decide you need counseling?
2. What do you wish to accomplish in counseling?
3. How have you dealt with problems in the past?
4. Have you been involved in counseling before? If so how was the experience?
5. List 4 words that best describe you.

1. _____
2. _____
3. _____
4. _____