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Licensed Psychologist

YOUTH INTAKE FORM

Youth's Name: _____Today's Date: _____

Those living in the home / Those living in one parent's home:

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

☐ Check if parents are separated or divorced. Attach custody agreement / order unless both parents are consenting to clinical services.

If applicable, those living in the other parent's home (if shared custody place name in both homes) (if visitation arrangement place name in home of custodial parent):

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

1. PRESENTING PROBLEM

Describe the youth's problem(s) that brought you here today:

Check any of the symptoms that the youth has been having:

Depressed mood		Feels hopeless	
Extreme sadness		Tearful/crying spells	
Trouble concentrating		Memory problems	
Change in sleeping habits		Lack of energy	
Security blanket or object		Stuttering	
Bedwetting		Thumb sucking	
Change in eating habits		Weight/appetite changes	
Problems getting along with family		Problems getting along with friends	
Doesn't seem to enjoy usual activities		Feeling of extreme happiness	

This space reserved for additional comments by Dr. Johannsen:

Date: _____ Youth's Name: _____

Trouble doing school work		Truancy	
Feeling stressed		Irritability	
Low self-esteem		Isolation/withdrawal	
Perfectionistic		Expresses feelings of guilt	
Worries		Seems nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Tense/uptight	
Anger outbursts		Acting violently	
Running away		Harm to animals	
Has hurt or cut on them self		Fire setting	
Thoughts of killing self		Thoughts of killing others	

Has the youth been in treatment before for these problems? **Yes** ☐ **No** ☐

If yes, describe it below, starting with the most recent first.

Dates of most recent therapy?
What was the therapist's name?
Explain what happened:
Dates of earlier therapy?
What was the therapist's name?
Explain what happened:

Have psychiatric medications been prescribed? **Yes** ☐ **No** ☐

What medications?	How much?	How often?	What reason?
1.			
2.			
3.			

Date: _____ Youth's Name: _____

2. SUBSTANCE USE HISTORY (If Applicable) **CHECK HERE IF N/A** ☐

Does the youth use tobacco (any form)?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the youth use alcohol?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the youth use caffeine (any form, including cola drinks)?	Current ☐	Suspected ☐	Past ☐	No ☐
Does the youth use recreational drugs?	Current ☐	Suspected ☐	Past ☐	No ☐

3. MEDICAL INFORMATION

Has the youth seen a doctor within the last year?		Yes ☐	No ☐
What was that for?			
Who is the youth's doctor?	Phone:		
Is the youth currently taking **non-psychiatric** medications?		Yes ☐	No ☐
What medications?	How much?	How often?	What reason?
1.			
2.			
3.			
Please list any major medical problems that the youth has had such as chronic illness, serious illness, surgeries, injuries or trauma to the head, etc.:			
Does the youth have allergies to anything?		Yes ☐	No ☐
Describe any allergy problems that he or she may have:			
Are there current problems with sleeping?		Yes ☐	No ☐
Are there current problems with eating?		Yes ☐	No ☐
Are there current problems with toileting?		Yes ☐	No ☐
Describe the sleeping, eating, or toileting problem(s):			

Date: _____ Youth's Name: _____

4. DEVELOPMENTAL HISTORY

Were there any problems with the pregnancy or the delivery of the youth?	Yes ☐ No ☐
Any problems with eating, sleeping or crying spells (colic, nightmares, etc.)?	Yes ☐ No ☐
Were there difficulties or delays in walking, talking, toilet training?	Yes ☐ No ☐
Have there been any family crisis such as marital separation or divorce?	Yes ☐ No ☐
Have there been any mental health problems in the family of origin?	Yes ☐ No ☐
Have there been any substance use or abuse issues in the family?	Yes ☐ No ☐
Briefly describe the youth's relationship to parents:	
Briefly describe the youth's relationship to siblings:	
Briefly describe the youth's temperament:	
Has the child had very upsetting events (violence, accidents, loss, abuse)?	Yes ☐ No ☐
If yes, please describe what it was and how it affected the child:	

5. SCHOOL

Current Grade In School	School & Contact Person	School Address & Phone

Date: _____ Youth's Name: _____

Have you been working with the youth's teacher or school counselor? Yes ☐ No ☐

If yes, please describe it below.

Name of teachers or counselors: What has been done? 504 Plan? IEP? Dates(s):

What age did the youth start school?
Were there any problems with starting school? Yes ☐ No ☐
What problems have come up during the school years?
What grades is the youth getting now?
Describe any changes in the youth's school performance:
How does the youth get along with his or her teachers?
How does the youth get along with his or her friends or peers in school?
What are the youth's favorite subjects or school activities?
What subjects or activities does the youth have problems with?