DOWNTOWN COUNSELING CENTER
Carlisle: 155 S. Hanover St., Carlisle, PA 17013 PH: (717) 386-5971 FAX: (717) 386-5635
Camp Hill: 412 Erford Road, Camp Hill, PA 17011 PH: (717) 305-2700 F: (717) 305-2719
www.dcc-pa.com

CHILD/ TEEN INTAKE INFORMATION FORM

Please complete this form.
If being seen at CARLISLE either submit/send to main@dcc-pa.com prior to the child/teen's intake appointment or bring the completed form with you to the intake appointment.

If being seen at CAMP HILL either submit/send to main2@dcc-pa.com prior to the child/teen's intake appointment or bring the completed form with you to the intake appointment.

Please know this form is reviewed during the intake appointment and if not complete prior to the child/teen's scheduled intake appointment, the appointment will be delayed and may have to be rescheduled.

Part 1 – IDENTIFYING DATA

Child/Teen Name *(First, Middle, Last)*	Age:	Date of Birth:	Gender: Male: ☐ Female: ☐ Other: ☐ (please specify):

Name of Person completing this form *(First, Middle, Last)*	Relationship to the Child/Teen:	Today's Date:

Name of Legal Guardians (if different from person completing information):

Address:

Home Phone:	Work Phone:
Cell phone:	E-mail address:

Part 2 – PRESENTING PROBLEM

What is (are) your reason(s) for bringing the child/teen today? What do you want to work on in treatment?

How long has the child/teen been experiencing these problems?

Has the child/teen had difficulties like this before that went away and are now back? ☐ Yes ☐ No *(If yes, please explain)*

Is the child/teen having suicidal thoughts at this time or recently? ☐ Yes ☐ No *(If yes, please explain)*

Is the child/teen engaging in self-injurious behavior at this time or recently? ☐ Yes ☐ No *(If yes, please explain)*

Is the child/teen having aggressive/violent thoughts at this time or recently? ☐ Yes ☐ No *(If yes, please explain)*

Is the child/teen having homicidal thoughts at this time or recently? ☐ Yes ☐ No *(If yes, please explain)*

Any other safety concerns at this time?

Does the child/teen have any current or past traumatic events? ☐ Yes ☐ No *(If yes, please explain)*

Part 3 – PAST PSYCHIATRIC HISTORY

List any previous psychiatric or substance abuse evaluations, counseling/ therapy, or hospitalizations:

Reason	Location	Dates	Problem or Diagnosis (if known)

List any **previous** psychiatric medications the child/teen has taken:

Medication	Dates	Effectiveness	Side Effects	Reason for Discontinuation

Part 4 – RISK ASSESSMENT HISTORY

Has the child/teen had suicidal thoughts in the past? ☐ Yes ☐ No *(If yes, please explain)*

Has the child/teen ever attempted suicide in the past? ☐ Yes ☐ No *(If yes, please explain)*

Has the child/teen engaged in self-injurious behavior in the past? ☐ Yes ☐ No *(If yes, please explain)*

Has the child/teen had homicidal thoughts in the past? ☐ Yes ☐ No *(If yes, please explain)*

Has the child/teen ever attempted homicide in the past? ☐ Yes ☐ No *(If yes, please explain)*

Part 5 – FAMILY PSYCHIATRIC HISTORY

List any family members who have been diagnosed or treated for any mental health problems?

Relationship	Problem/Diagnosis	Hospitalized	Medications prescribed?
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Have there been any deaths due to suicidal behavior in the family? ☐ Yes ☐ No *(If yes, please explain)*

Part 6 – MEDICAL HISTORY

Name and Location of Health Care Provider/ Pediatrician:	Name of Health Care Facility and Office Phone of Health Care Provider/ Pediatrician:

List all non-medication allergies and allergic reactions:

List medication allergies and adverse reactions to medications:

List all psychiatric and non-psychiatric medications the child/teen is currently taking (please continue in Part 18 if more space required:

Name of Drug	Amount taken (dose)	Name of Prescriber	Name of Drug	Amount taken (dose)	Name of Prescriber

List all current and past medical or physical problems, including hospitalizations and traumatic injuries:

Is the child/teen currently experiencing severe pain, fever, dizziness, or lightheadedness? ☐ Yes ☐ No *(If yes, please explain below)*

List any over the counter medications	Herbal products	Supplements/Vitamins

Part 6A - PAIN ASSESSMENT

Is the child/teen currently experiencing any physical pain? ☐ Yes ☐ No *(If yes, please explain below)*

(If experiencing pain, please score pain on a 10-point scale where 0 = no pain and 10 = worst pain imaginable)

Please score child/teen pain: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Good pain day: /10 **Average pain day: /10** **Bad pain day: /10**

What does the child/teen do to help manage pain on severe pain days?

Part 7 – SUBSTANCE USE ASSESSMENT

AUDIT Screening Tool	0	1	2	3	4
Instructions: Please check the box that most applies to you.	**Never**	**Monthly or less**	**2-4 times monthly**	**2-3 times weekly**	**4 + times weekly**
1. How often does the child/teen have a drink containing alcohol?	☐	☐	☐	☐	☐
2. How many drinks containing alcohol does the child/teen have on a typical day when they are drinking?	**1-2** ☐	**3-4** ☐	**5-6** ☐	**7-9** ☐	**10+** ☐
	Never	**Monthly or less**	**Monthly**	**Weekly**	**Daily or almost daily**
3. How often does the child/teen have six or more drinks on one occasion?	☐	☐	☐	☐	☐
4. How often during the last year has the child/teen found they were not able to stop drinking once they had started?	☐	☐	☐	☐	☐
5. How often during the last year has the child/teen failed to do what was normally expected of them because of drinking?	☐	☐	☐	☐	☐
6. How often during the last year has the child/teen needed a first drink in the morning to get themself going after a heavy drinking session?	☐	☐	☐	☐	☐
7. How often during the last year has the child/teen had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐
8. How often during the last year has the child/teen been unable to remember what happened the night before because of drinking?	☐	☐	☐	☐	☐
	Never		**Yes, but not in last year**		**Yes, during the last year**
9. Has the child/teen or someone else been injured as a result of their drinking?	☐		☐		☐
10. Has anyone been concerned about the child/teens drinking or suggested they cut down	☐		☐		☐
Total AUDIT Score ←					

What, if any, recreational or illicit drugs or medications has the child/teen used recently or in the past?

How frequently does the child/teen use marijuana, CBD, or other drugs?

In the past year, has the child/teen ever drunk alcohol, used marijuana, CBD, or other drugs more than they intended? ☐ Yes ☐ No

In the past year, has the child/teen felt they wanted or needed to cut down on alcohol, marijuana, CBD or other drug use ☐ Yes ☐ No

Has the child/teen needed to drink more alcohol or use more marijuana, CBD, or other drugs to get the same effect, or have they realized they could no longer get high on the same amount they were using? ☐ N/A ☐ Yes ☐ No

TOBACCO USE	CAFFEINE USE
Does the child teen smoke or use tobacco products? ☐ Yes ☐ No *(If no please go to next section)*	How many caffeinated beverages does the child/teen consume per day on average?
What does the child/teen smoke or use? ☐ Cigarettes ☐ Snuff ☐ Cigars ☐ Pipe ☐ E-Cigarettes/Vape	
How much do they use in a day?	Does the child/teen feel irritable, jumpy or nervous because of their caffeine use? ☐ Yes ☐ No
How long have they been using tobacco products?	
Do they wish to quit? ☐ Yes ☐ No	Does caffeine use impair their sleep? ☐ Yes ☐ No
Do they wish to receive information on Tobacco Cessation? ☐ Yes ☐ No	
Do they wish to receive treatment for Tobacco Cessation? ☐ Yes ☐ No	

PART 8 – PSYCHOSOCIAL / DEVELOPMENTAL HISTORY

Where was the child/teen born and raised?	Who raised child/teen? ☐ Both Parents ☐ Mother ☐ Father ☐ Other Family: ☐ Foster Parent(s) ☐ Adoptive Parent(s) ☐ Other:

Were there any complications at birth? ☐ Yes ☐ No *(If yes, please explain below)*

How many siblings does the child/teen have and what number child were they?

What is it like in the child/teens home? ☐ Loving ☐ Comfortable ☐ Supportive ☐ Chaotic ☐ Abusive ☐ Other:

What type of discipline is used in the child/teens home?

Does the child/teen have any developmental delays or problems? ☐ Yes ☐ No *(If yes, please explain below)*

Has the child/teen ever been physically, sexually or emotionally abused? : ☐ Yes ☐ No *(If yes, please explain)*

Part 9 - CURRENT FAMILY RELATIONSHIP ASSESSMENT

Parent's Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	If parents are married, how long have they been married?

Are parents currently having any stressors or problems in the marriage or relationship? ☐ Yes ☐ No ☐ N/A *(If yes, please explain)*

Have parents been married previously? ☐ Yes ☐ No ☐ N/A *(If yes, please explain)*

Are there any concerns about domestic violence or abuse? ☐ Yes ☐ No *(If yes, please explain)*

Have the parents or child/teens legal guardians ever been referred to any agency such as Child Protective Services?
☐ Yes ☐ No *(If yes, please explain)*

Please list all the children that live with the child/teen : ☐ N/A (continue below, if needed)

Child's name	Child's age	Child's Gender	Biological or stepchild		Does this child currently reside with you?
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Does anyone else reside in the child/teen household?	☐ Yes ☐ No	*(If yes, please explain below)*
Are there any behavior health problems with any of the child/teens siblings?	☐ Yes ☐ No	

Any other family relationship concerns at this time: ☐ Yes ☐ No. (if Yes, please explain):

Part 10 - SOCIAL SUPPORT ASSESSMENT

Does the child/teen have someone to talk to when they have a problem?	☐ Yes ☐ No
Is there someone the child/teen would ask for help if they needed it?	☐ Yes ☐ No
Is the child/teen geographically separated from family and friends?	☐ Yes ☐ No
Is the child/teen having trouble with their relationships with family, friends or students at school?	☐ Yes ☐ No
Has the child/teen recently withdrawn from family or friends?	☐ Yes ☐ No

Does the child/teen belong to any groups or organizations that are supportive and helpful? ☐ Yes ☐ No *(If yes, please explain)*

Part 11 – SPIRITUAL/ CULTURAL ASSESSMENT

What is the child/teen's religious, spiritual, or cultural affiliation?

How much is the child/teens religion or spirituality a source of strength or comfort to them?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

How much is the child/teens religion or spirituality a source of strength or comfort to them?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

How much is the child/teen's spiritual community a source of support?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

How much is the child/teen's cultural/ethnic heritage a source of strength or comfort?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

How much is the child/teen's cultural/ethnic heritage a source of support?
☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

Does the child/teen have any religious, spiritual, or cultural practices or preferences that your provider needs to be aware of during treatment? ☐ Yes ☐ No *(If yes, please explain).*

Part 12 - EDUCATIONAL ASSESSMENT

What is the child/teen's current school grade?

Is the child/teen currently attending school? ☐ Yes ☐ No. (If no, please explain)

What are the child/teen's typical grades?
Are current grades different from past grades: ☐ Yes ☐ No. (If Yes, please explain)

Did child/teen repeat or skip any grades? ☐ Yes ☐ No If yes, please explain:

Does the child/teen attend any special education or gifted classes? ☐ Yes ☐ No If yes, please explain:

Does the child/teen have any learning disabilities? ☐ Yes ☐ No If yes, please explain:

Does the child/teen have any disciplinary problems in school? ☐ Yes ☐ No If yes, please explain:

If yes, were they ever suspended or expelled?
☐ Yes ☐ No. If yes, please explain:

PART 13 - LEGAL ASSESSMENT

Has the child/teen ever been arrested?	☐ Yes ☐ No	*(If yes, please explain below)*
Is the child/teen currently on probation or parole?	☐ Yes ☐ No	
Does the child/teen have any other legal problems?	☐ Yes ☐ No	

Part 14 – SEXUAL ASSESSMENT

Is the child/teen experiencing any sexual concerns?	☐ Yes ☐ No	*(If yes, please explain below)*
Has the child/teen ever been sexually abused, assaulted or harassed?	☐ Yes ☐ No	

Part 15 – LEISURE, RECREATIONAL AND VOCATIONAL ACTIVITIES

What does the child/teen like to do in their free time?

Is there anything that limits their ability or desire to participate in leisure and recreational activities?

Part 16 – NUTRITIONAL ASSESSMENT

Height	Weight	In the last month has the child/teen gained or lost weight without trying? ☐ Yes ☐ No *(If yes, please explain below)*

How many meals does the child/teen eat per day?

Has the child/teen ever had problems with: *(If checked, please explain)*
☐ Being overweight ☐ Being underweight ☐ Binge eating ☐ Compulsive overeating
☐ Vomiting ☐ Laxative Abuse ☐ Excessive dieting ☐ Diuretic (Water pill) Abuse
☐ Other eating disorders/problems:

Part 17 - FINANCIAL ASSESSMENT

Does the child/teen or family currently have any financial problems?
☐ Yes ☐ No. *(if Yes, please explain):*

Part 18 – PATIENT DISCLOSURE

Please use this space to tell us anything additional that you may feel is relevant or may be important for your provider to know.

Patient Signature and Date: _____

Please list any individuals you consent to have contacted to discuss your treatment and/or coordinate care. **If interested in having Therapist contact any of the below individuals,** please provide required information below and obtain a Release of Information Form from the Front Desk and give to you Therapist. **If not interested in coordination of care leave blank.**

☐ Spouse (Name) :	Address:	Phone number:
☐ Work Supervisor (Name):	Address:	Phone number:
☐ Doctor (Name):	Address:	Phone number:
☐ Other Person/ Agency (Name):	Address:	Phone number: