

Youth Intake Interview Form

Today's Date: _____

Youth's Name _____

First

Middle

Last

Address: _____

Birth Date: _____

Male/Female: _____

Phone: () _____

Social Security #: _____

Place of Birth: _____

Insurance Co: _____

Mother's Name _____

Father's Name _____

DOB: _____ Occupation: _____

DOB: _____ Occupation: _____

Address _____

Address _____

Phone (H) _____ (W) _____

Phone (H) _____ (W) _____

Persons Present for Assessment: _____

Self identified race/ethnicity/cultural heritage _____

Language youth/family speak at home (if not English) _____

EDUCATIONAL INFORMATION

School Building: _____ Grade: _____

Credits: _____ GPA: _____ IEP? ___No ___Yes: _____

Ever been diagnosed with ADHD? ___No ___Yes: _____

Attendance Pattern: ___Regular ___Skips ___Tardies

What are your Academic Goals?: ___GED ___Diploma ___Trade School ___College

Explain: _____

Do you participate in any school sports? _____

Are you in any clubs or other school activities? _____

What do you like best about school? _____

What do you like least about school? _____

What is your favorite class/subject? _____

Have you ever been suspended? ___No ___Yes: _____

Have you ever been expelled? ___No ___Yes: _____

Do you have a history of fighting in school? ___No ___Yes: _____

Is there a teacher, counselor, coach, or other adult at school that you can talk to? ___No ___Yes: _____

Guidance Counselor: _____

Do the parents help/support youth in school? ___No ___Yes: _____

How did youth do in school in the past? (elementary, middle school, grades, fighting, suspensions):

Additional Notes: _____

FAMILY STRUCTURE/LIVING SITUATION

Individual Lives with:

___ Father ___ Stepfather ___ Legal Adoption
___ Mother ___ Stepmother ___ Relatives: _____
___ Both (biological) ___ Other: _____

Who else lives in the home? (siblings, relatives, significant others, etc.) _____

Home Environment:

Describe the relationships and communication within the home (conflicts, how people get along): _____

What are your rules at home? _____

What consequences do you typically face when you don't follow the rules? _____

What consequences did you face at home for this referral? _____

What are some things you do together as a family? _____

Significant family events, traumas, or major changes/Dates: _____

What are some strengths you have as a family? _____

What adult do you spend most of your time with? (Looking for a positive adult role model)
Name: _____ Relationship: _____

Which extended family members provide support and how?
Name: _____ Relationship: _____

History of running away: ___No ___Yes: (How often, most recent occurrence) _____

Any previous out of home placements?: _____

Family Criminal History:
Mother: ___No ___Yes, Crime(s): _____
Father: ___No ___Yes, Crime(s): _____
Siblings: ___No ___Yes, Crime(s): _____
Relatives: ___No ___Yes, Crime(s): _____

Additional Notes: _____

YOUTH

What do you like to do for fun? (favorite hobbies/interests) _____

What are some things that you're good at? _____

What are some things your child is good at? _____

How would you describe yourself? _____

Do you go to any youth groups, church groups, or clubs? _____

Have you ever had a job? _____

Are there positive people in your life who serve as a resource/mentor for you?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Additional Notes: _____

PEERS

How would you describe your friends? _____

Lots of Friends Few Friends No Friends

Mostly Older Mostly Younger Same Age

Do parents know and approve of friends? No Yes, Comments: _____

Have your friends changed over time? How/Why? _____

Have any of your friends gotten into trouble with the law? No Yes: _____

How do your friends do in school? (grades, attendance, behavior) _____

What do you value in a friend? _____

MEDICAL

Does youth, or has youth ever, taken medication? No Yes: _____

Any pregnancy, delivery, or developmental milestone (walking, talking, potty training) concerns?

Is there any history of head injury? No Yes: _____

Any past hospitalizations, serious injuries, or frequent or chronic illnesses? _____

MENTAL HEALTH

Have you ever received any psychological or counseling services? No Yes: _____

Have you ever attempted suicide? No Yes: _____

Have you ever had suicidal thoughts or gestures? No Yes: _____

Any history of depression or withdrawal? No Yes: _____

Any history of sleeping or eating problems? No Yes: _____

Any auditory or visual hallucinations? No Yes: _____

Family History of Mental Illness:

Mother: No Yes, Explain: _____

Father: No Yes, Explain: _____

Siblings: No Yes, Explain: _____

Relatives: No Yes, Explain: _____

Have any family members been in counseling or treatment for mental illness or substance abuse?

Additional Notes: _____

Victimization/Abuse:

Physical Abuse? No Yes: _____

Emotional Abuse? No Yes: _____

Sexual Abuse? No Yes: _____

DRUG AND ALCOHOL

History: (date/age of first use, date/age of last use, heaviest use, frequency, tolerance, method of ingestion, etc.)

Alcohol ___ No ___ Yes: _____

Marijuana ___ No ___ Yes: _____

Mushrooms ___ No ___ Yes: _____

Acid ___ No ___ Yes: _____

Methamphetamine ___ No ___ Yes: _____

Cocaine ___ No ___ Yes: _____

Pills ___ No ___ Yes: _____

Heroin ___ No ___ Yes: _____

Inhalants (huffing) ___ No ___ Yes: _____

Cigarettes ___ No ___ Yes: _____

Other: _____

Drug of choice: _____

Have you ever been under the influence of drugs or alcohol while at school? ___ No ___ Yes

Have you ever (unsuccessfully) attempted to quit using drugs or alcohol before? ___ No ___ Yes: _____

Has anything bad ever happened to you because of your drug or alcohol use? (school, home, legal, friends, work) ___ No ___ Yes: _____

Have you ever done a “wake and bake”? ___ No ___ Yes

Have you ever combined drugs in order to enhance an effect? (stacking) ___No ___Yes
Have you ever used one drug to counteract the effects of another drug? (morphing) ___No ___Yes
Have you ever been in drug and alcohol treatment or received an assessment? ___No ___Yes: _____

Family Substance Abuse:

Mother: ___No ___Yes, Substance(s): _____
Father: ___No ___Yes, Substance(s): _____
Siblings: ___No ___Yes, Substance(s): _____
Relatives: ___No ___Yes, Substance(s): _____

Additional Notes: _____

SAFETY

Are any weapons available in the home, or does youth have access to weapons? ___No ___Yes: _____
Does youth have preoccupation with or use of weapons? ___No ___Yes: _____
Any history of fire setting? ___No ___Yes: _____
Any history of animal abuse? ___No ___Yes: _____
Any concerns about anger management or impulsivity? _____

REPAIRING HARM

Who was hurt by your actions? _____
What have you already done to make up for your actions? _____
Is there anything else you could do? _____
What can you do to show people you will make better choices in the future? _____

GOALS

What are some of your short-term goals? (within the next month) _____
What are some of your long-term goals? (within the next year) _____

What are some goals you would like to work on with me? _____

How can I help you achieve these goals? _____

Additional Notes: _____

SHORT TERM COMPETENCY DEVELOPMENT/SKILL BUILDING AREAS
PLANNING/GOALS

1. **POSITIVE ADULT:** Is there a positive adult to support the youth with meeting the goals?
If not, GOAL: _____

2. **HEALTHY IDENTITY:** Is the youth involved in any positive activities or pursue any
positive interests? If not, GOAL: _____

3. **COMMUNITY CONNECTIONS:** Is the youth engaged with any educational/vocational
activities or involved in any community groups or resources? If not, GOAL: _____

4. **REPAIRING HARM:** Has the youth taken responsibility for his/her actions; do he/she
understand the impact of his/her behavior; has he/she made efforts to repair harm? If not,
GOAL: _____

