ADOLESCENT INTAKE

Teens 14-17

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Birthdate _____ Gender _____

Describe the reason you are bringing your child for counseling

_____

Who referred you to JFS/Mynd Works?

_____

Preferred method of contact (choose one and provide contact information):

☐ Email ☐ Text ☐ Phone

_____ _____ _____

Family Information

Parent/Guardian _____ Birthdate _____ Relation _____

Primary Phone _____

Address (if different) _____

City _____ State _____ Zip _____

Parent/Guardian _____ Birthdate _____ Relation _____

Primary Phone _____

Address (if different) _____

City _____ State _____ Zip _____

Insurance Company _____

Member ID _____

Phone number on the back _____

Policy holder _____ Policy Holder Date of Birth _____

Please list ALL persons living with the child (including parents/guardians):

Name	Relationship to Child	Date of Birth	Gender	Marital Status	Employer/Occupation

Please list family members NOT living with the child (Parent, Siblings, Stepparents, Birth Parents, etc.):

Name	Relationship to Child	Date of Birth	Gender	Marital Status	Employer/Occupation

Family's religious, spiritual, cultural, or sexual identity information you wish to share

Is the child now or has the child been in any of the following?

☐ Foster Care ☐ Custody of Relative ☐ Adopted

If yes, please briefly describe the situation

Social

How does the child get along with peers/friends?

How does the child get along with parents/caregivers or other adults?

How does the child get along with sibling(s)?

Does the child have hobbies or participate in activities (sports, school clubs, scouts, etc.)?

Educational

Current Grade

School/School District

What other schools has the child attended?

Does the child have an Individualized Education Plan (IEP)? ☐ YES ☐ NO

If yes, what type?

- ☐ Autism
- ☐ Deaf/Blindness
- ☐ Deafness
- ☐ Emotional disturbance
- ☐ Hearing impairment
- ☐ Intellectual disability
- ☐ Multiple disabilities
- ☐ Orthopedic impairment
- ☐ Other health impairment
- ☐ Specific learning disability
- ☐ Speech or language impairment
- ☐ Traumatic brain injury
- ☐ Visual impairment

Does the child have academic, attendance, or behavioral issues? ☐ YES ☐ NO

If yes, please describe:

Developmental History

Was the baby carried to term? ☐ YES ☐ NO

Birth Weight:

Did mother or child experience medical complications during pregnancy, delivery, or following delivery?
☐ YES ☐ NO

If yes, please briefly describe

Did the child meet developmental milestones (walking, talking, toilet-training, school readiness skills, etc.) at expected ages? ☐ YES ☐ NO

If no, please briefly describe

Physical and Mental Health History

Has the child been prescribed any medication(s)? ☐ YES ☐ NO

If yes, please provide the following:

Name	Dosage	Frequency	Reason For Taking	Who prescribed it?

Does the child have any allergies? ☐ YES ☐ NO

If yes, please describe:

Please check all that apply to the child, and describe briefly if checked:

- ☐ current medical conditions
- ☐ medical problems in the past
- ☐ sleep problems
- ☐ problems with eating habits
- ☐ problems with personal hygiene
- ☐ other health concerns

Does the child have any previous mental health diagnosis? ☐ YES ☐ NO
If yes, please list:

If yes, who gave the diagnosis and when?

Has the child ever been involved with any of the following services?

Previous	Current		Approx. Date/Name of Provider/Agency
☐	☐	Outpatient Counseling/Therapy	
☐	☐	Psychological evaluation	
☐	☐	Psychiatric evaluation	
☐	☐	Psychiatric Med. Management	
☐	☐	BHRS Services (BSC, MT, TSS)	
☐	☐	Family-Based Mental Health	
☐	☐	Speech/Language Therapy	
☐	☐	Occupational Therapy	
☐	☐	Children & Youth/CPS	
☐	☐	Other (describe):	

.Has the child experienced any of the following (if yes, please briefly describe the situation)?

- ☐ abuse-physical, emotional, or sexual
- ☐ witnessing domestic violence
- ☐ prolonged separations from parents or caregivers)
- ☐ other trauma

Please indicate if any person in the child's birth or adoptive family has experienced the following:

	Name/Relationship to the child:
☐ ADHD	
☐ Anxiety Disorder	
☐ Bipolar Disorder	
☐ Chronic Physical Illness	
☐ Depression	
☐ Drug and/or Alcohol Abuse	
☐ Learning Problems	
☐ Other Physical or Mental Illness	
☐ Schizophrenia	

Please describe the child's overall strengths and areas of concern:

☐ *By checking this box AND typing my name, I am verifying that this is my electronic signature*

Signature of Person Completing Form | Relationship to Child | Date

ADVERSE CHILDHOOD EXPERIENCE QUESTIONNAIRE

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?
If yes enter 1 _____

2. Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
If yes enter 1 _____

3. Did an adult person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
If yes enter 1 _____

4. Did you often or very often feel that …No one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
If yes enter 1 _____

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
If yes enter 1 _____

6. Were your parents ever separated or divorced?
If yes enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?
If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
If yes enter 1 _____

10. Did a household member go to prison?
If yes enter 1 _____

Now add up your "Yes" answers: 0 this is your ACE Score.