



560 N. Exposition  
Wichita, KS 67203  
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## Child/Youth Intake Form

### CHILD'S INFORMATION:

NAME: \_\_\_\_\_ FCS ID#: \_\_\_\_\_ KAECSSES #: \_\_\_\_\_  
First name Middle Initial Last Name

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SS NUMBER: \_\_\_\_\_ GENDER:  MALE  FEMALE

ADDRESS: \_\_\_\_\_ APT.#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_  
Home Cell

RACE/ETHNICITY OF CHILD  
 African American/Black  Asian  Caucasian/White  Chinese  Hawaiian  Japanese  Native American  Vietnamese  Hispanic  Biracial  Other

Are there any communication barriers for the child or parent/guardian? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

### CAREGIVER INFORMATION:

PARENT  RELATIVE  GUARDIAN  RESOURCE PARENT

NAME: \_\_\_\_\_  
Last name First Name Middle Initial

ADDRESS: (if different) \_\_\_\_\_ APT.#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_  
Home Cell Work

Number of household members: \_\_\_\_\_

Are there any immediate family members in the military? \_\_\_\_\_ If so, have they served in combat? \_\_\_\_\_

Who is legally authorized to receive information about and make decisions regarding this child's care?

\_\_\_\_\_  
Name and Relationship

CASE MANAGER/ PO: \_\_\_\_\_ AGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_  N/A

WHO REFERRED YOU TO OUR AGENCY: \_\_\_\_\_

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT FOR THIS CHILD: \_\_\_\_\_

IS TREATMENT COURT ORDERED? YES  NO

EMPLOYMENT INFORMATION:  Full-time Student  Part-time Student  Employed  N/A

Name of Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

### LEGAL HISTORY:

Has the child been charged with a crime  Yes  No Is the child on probation?  Yes  No

If yes, please explain: \_\_\_\_\_

Child's Name: \_\_\_\_\_

**SUBSTANCE USE HISTORY:**

NONE

Alcohol     Other substance use \_\_\_\_\_

Attended alcohol/drug abuse treatment:  Yes  No    Has the child been told that they have an alcohol/drug problem:  Yes  No

**SCHOOL FUNCTIONING:**

Current School: \_\_\_\_\_  Elementary     Middle School     High School

Grade: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_ School Phone Number: \_\_\_\_\_

Past / Present truancy    Yes     No

Expulsions    Yes     No     Number \_\_\_\_\_    Dates \_\_\_\_\_

Suspensions    Yes     No     In school     Out of school     Number \_\_\_\_\_    Dates \_\_\_\_\_

Asked to leave a daycare/preschool    Yes     No     Number \_\_\_\_\_    Dates \_\_\_\_\_

504 Plan     Special Education / IEP \_\_\_\_\_

**SOCIAL, PLAY AND RECREATION:** Describe the child's social, play and recreational interests:

\_\_\_\_\_  
\_\_\_\_\_

**PLACEMENT HISTORY:**  N/A

Type: Resource home, shelter, residential facility \_\_\_\_\_ Kinship home

Dates/length of stay: \_\_\_\_\_

Reason for moving: \_\_\_\_\_

Type: Resource home, shelter, residential facility \_\_\_\_\_ Kinship home

Dates/length of stay: \_\_\_\_\_

Reason for moving: \_\_\_\_\_

*Please document additional placements on a separate page*

**CASE PLAN GOAL**  Reintegration  Adoption  Guardianship  Maintenance at Home  OPPLA  NA

**CONCURRENT CASE PLAN GOAL**  Adoption  Guardianship  OPPLA  NA

**MENTAL HEALTH HISTORY:**

No previous therapy

Outpatient Treatment

Type of treatment: (Circle all that apply)    Individual therapy    family therapy    group therapy

Provider: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Type of treatment: (Circle all that apply)    Individual therapy    family therapy    group therapy

Provider: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_

Reason for treatment: \_\_\_\_\_

Child's Name: \_\_\_\_\_

**INPATIENT PSYCHIATRIC HOSPITALIZATION:**

Previously hospitalized:  Yes  No  N/A Multiple Hospitalizations:  Yes \_\_\_\_\_

Last psychiatric facility \_\_\_\_\_ Date Admitted \_\_\_\_\_ Date Dismissed \_\_\_\_\_

*Please document additional hospitalizations on a separate sheet*

**PRIMARY CARE PHYSICIAN (PCP):**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Visit/Checkup with PCP within the past 12 months:  YES  NO Regular preventative health screens:  YES  NO

**CURRENTLY PRESCRIBED MEDICATIONS** (Medication, dosage and prescribing physician):

\_\_\_\_\_

Has the child been consistently taking these medications as prescribed  Yes  No

**PATIENT MEDICAL/PSYCHIATRIC HISTORY:** (Please check those that apply)

- |                                      |  |   |  |                                      |
|--------------------------------------|--|---|--|--------------------------------------|
| <input type="checkbox"/> ASTHMA      | <input type="checkbox"/> HIGH BLOOD PRESSURE     | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> DENTAL PROBLEMS | <input type="checkbox"/> ADHD        |
| <input type="checkbox"/> CANCER      | <input type="checkbox"/> THYROID PROBLEMS        | <input type="checkbox"/> LIVER DISEASE  | <input type="checkbox"/> TUBERCULOSIS    | <input type="checkbox"/> ANXIETY     |
| <input type="checkbox"/> DIABETES    | <input type="checkbox"/> SEASONAL ALLERGIES      | <input type="checkbox"/> HEART DISEASE  | <input type="checkbox"/> ABUSE: PHYSICAL | <input type="checkbox"/> DEPRESSION  |
| <input type="checkbox"/> HEAD INJURY | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> SEIZURES       | <input type="checkbox"/> ABUSE: SEXUAL   | <input type="checkbox"/> OTHER _____ |

History of hospitalization due to a medical condition:  YES  NO IF YES, \_\_\_\_\_

Medication Allergies \_\_\_\_\_ Food Allergies \_\_\_\_\_

**DEVELOPMENTAL HISTORY:**

PREGNANCY:  FULL TERM  PREMATURE  LATE DELIVERY:  NORMAL DELIVERY  C-SECTION

Problems during pregnancy \_\_\_\_\_

MILESTONES:

WALKING \_\_\_\_\_ MONTHS TALKING \_\_\_\_\_ MONTHS TOILET TRAINED \_\_\_\_\_ MONTHS

**FAMILY MEDICAL HISTORY:** (Please mark each that apply with "1" for immediate family "2" for extended family)

- |                |                      |  |                                  |
|----------------|----------------------|--|----------------------------------|
| ___ Diabetes   | ___ Heart Disease    | ___ Anxiety  | ___ Psychiatric hospitalizations |
| ___ Depression | ___ Schizophrenia    | ___ Suicide attempts                                     | ___ Alcohol/drugs                |
| ___ ADHD       | ___ Bipolar Disorder | ___ Antisocial behavior (difficulties – police/violence) |                                  |

**VISITATION ARRANGEMENTS:**

Are there any custody/visitation arrangements? Please describe, noting any court orders:

\_\_\_\_\_

**FAMILY, CULTURE AND RELIGION:** Describe the child's family, cultural and religious connections.

\_\_\_\_\_

**BEREAVEMENT AND GRIEF:** Has the child experienced grief and or loss? If so, describe how your family is supported socially, spiritually and culturally. \_\_\_\_\_

\_\_\_\_\_

Child's Name: \_\_\_\_\_

**GENERAL FUNCTIONING:** (Please check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cheerful/happy mood most of the time         | <input type="checkbox"/> Extreme ups and downs in mood             | <input type="checkbox"/> Conflict with authority figures  |
| <input type="checkbox"/> Sad or tearful most of the time              | <input type="checkbox"/> Irritability/anger                        | <input type="checkbox"/> Stealing                         |
| <input type="checkbox"/> Feelings of hopelessness                     | <input type="checkbox"/> Distinct periods of nonstop activity      | <input type="checkbox"/> Physical cruelty to animals      |
| <input type="checkbox"/> Withdrawn behaviors                          | <input type="checkbox"/> Exaggerated view of abilities             | <input type="checkbox"/> Physical aggression              |
| <input type="checkbox"/> Difficulty thinking                          | <input type="checkbox"/> Fast/rapid speech                         | <input type="checkbox"/> Verbal threats to harm others    |
| <input type="checkbox"/> Under active/sluggish behavior               | <input type="checkbox"/> Feels rested after 3-4 hours sleep/ night | <input type="checkbox"/> Threat to kill with intent /plan |
| <input type="checkbox"/> Intentional self harm                        | <input type="checkbox"/> Fearless/engaging in reckless activities  | <input type="checkbox"/> Lying                            |
| <input type="checkbox"/> Suicidal thoughts                            | <input type="checkbox"/> Fearful of places, situations or people   | <input type="checkbox"/> Extreme conflict with siblings   |
| <input type="checkbox"/> Suicide attempts                             | <input type="checkbox"/> Worries about _____                       | <input type="checkbox"/> Running away                     |
| <input type="checkbox"/> Increased appetite                           | <input type="checkbox"/> Wetting accidents                         | <input type="checkbox"/> Poor social skills               |
| <input type="checkbox"/> Decreased appetite                           | <input type="checkbox"/> Soiling Accidents                         | <input type="checkbox"/> Inability to complete tasks      |
| <input type="checkbox"/> Nightmares                                   | <input type="checkbox"/> Sexual inappropriate touching of others   | <input type="checkbox"/> Inability to sustain attention   |
| <input type="checkbox"/> Takes more than an hour to fall asleep       | <input type="checkbox"/> Sexual play with toys or objects          | <input type="checkbox"/> Inability to remain seated       |
| <input type="checkbox"/> Night waking for longer than 30 minutes      | <input type="checkbox"/> Excessive masturbation                    | <input type="checkbox"/> Overactive/hyperactive behavior  |
| <input type="checkbox"/> Hard to wake up in the morning               | <input type="checkbox"/> Intentional vomiting/purging              | <input type="checkbox"/> Easily distracted                |
| <input type="checkbox"/> Unable to sleep in own bed through the night | <input type="checkbox"/> Hoarding food                             | <input type="checkbox"/> Difficulty concentrating         |
| <input type="checkbox"/> Sleepwalking                                 | <input type="checkbox"/> Binge eating                              | <input type="checkbox"/> Poor self-care/poor hygiene      |

**WHEN DID THESE CONCERNS BEGIN?**

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**HOW OFTEN DO THESE OCCUR?**

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**IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD?**

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**CONSENT AND AUTHORIZATION**

**By signing below you are:**

- Authorizing Youthville Family Consultation Service to provide the client with mental health services.
- Acknowledging that Youthville Family Consultation Service will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- Acknowledging that you have been informed that services not covered by the insurance company will be the responsibility of the client (or parent or guardian if the client is under 18 years of age).
- Acknowledging that you have received a copy of the Client Rights and Responsibilities.
- Acknowledging that you have signed a copy of the Financial Agreement & understand the terms of this agreement.

**CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)**

Signature X \_\_\_\_\_ Date \_\_\_\_\_  
Must Be Signed by Client or by Parent or Guardian if Client is Under 18 Years of Age.

*Youthville Family Consultation Service is an equal opportunity employer. Services are provided to people without regard to race, religion, color, sex, ancestry, national origin, handicap, age or political affiliation.*