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Youth Intake Packet

Thank you for selecting Meadowlark Counseling, LLC to help meet the needs of you and your family, we appreciate the opportunity to assist you in this important process.

If appropriate, it is recommended a parent or guardian fill out this form for/with their children.

Please download and email to office@meadowlarkgillette.com prior to your appointment for your provider to review. If you are not able to do so, please bring the questionnaire with to your appointment. If at any time in this process you have any questions, please contact us.

We look forward to serving you,

Meadowlark Counseling, LLC

YOUTH INTAKE QUESTIONNAIRE

So that we can best assist you, ***please fill out this form with information relevant to your treatment*** at Meadowlark Counseling.

Meadowlark Counseling, LLC will hold information provided by you strictly confidential and will only release information in accordance with HIPPA guidelines and as mandated by law.

PLEASE PRINT

Name of Person Completing this form: _____

Please describe your reason for seeking help at Meadowlark Counseling.

_____

_____

_____

Please mark any current, relevant symptoms and indicate how often they are present:

- ☐ Weight/ appetite changes _____
- ☐ Isolation _____
- ☐ Issues in social situations _____
- ☐ Issues making/keeping friends _____
- ☐ Unassertive _____
- ☐ Issues with sleep _____
- ☐ Suicidal thoughts _____
- ☐ Self-injurious behaviors _____
- ☐ Alcohol/ drug use _____
- ☐ Problems with temper _____
- ☐ Defiance _____
- ☐ Running away _____
- ☐ Threatening others _____
- ☐ Frequent lying _____
- ☐ Daytime fatigue/tiredness _____
- ☐ Nightmares _____
- ☐ Bed wetting/Soiling _____
- ☐ Anxiety _____
- ☐ Perfectionism _____
- ☐ Physical complaints (stomachache, etc.) _____
- ☐ Worries about food/weight _____
- ☐ Avoidance _____
- ☐ Intense fears _____
- ☐ Low motivation _____
- ☐ Too much screen time _____
- ☐ Picked on/bullied _____
- ☐ Sadness or Depression _____
- ☐ Concentration difficulties _____
- ☐ Easily distracted _____
- ☐ Impulsive _____
- ☐ Talks excessively/interrupts _____
- ☐ Problems with organization _____
- ☐ Loss of interest in activities _____
- ☐ Sensitivity to sensations _____
- ☐ Hallucinations _____
- ☐ Mood swings _____
- ☐ Morbid thoughts _____
- ☐ Relationship issues _____
- ☐ Changes in self-care _____
- ☐ Other _____

MENTAL HEALTH HISTORY

Any previous counseling? YES☐NO☐

If yes, when/where, and for what issues? _____

Please list any current medications used for emotional problems. Are they helpful?

_____

CURRENT LIVING SITUATION

Who do you currently live with?_____

Current Parent Marital Status: ☐Married ☐Divorced ☐Separated ☐Widowed ☐ Single ☐Cohabitants

Current Parent Spouse/Significant Other: Name _____

Children or siblings living in the home:

	Name	Age	Sex	Biological Parent(s) of Child
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Children or siblings ***not*** living in the home:

	Name	Age	Sex	Biological Parent(s) of Child/Location
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

List any other people who currently live with you:

	Name	Age	Relationship
1.	_____	_____	_____
2.	_____	_____	_____

Additional information about current living situation relevant to treatment:

_____

_____

SCHOOL & SOCIAL HISTORY

Current grade: _____

Current school: _____

OR Please check the highest level of education completed:

GED High School Diploma Grade:_____

SCHOOL & SOCIAL HISTORY CONT.

1. Favorite subject/class? _____
2. Least preferred subject/class? _____
3. Repeated a grade? YES ☐ NO ☐ If yes, what grade(s)?:_____
4. IEP/504 Plan? YES ☐ NO ☐ If yes, what grade(s)/classes?_____.
5. Behavioral issues in school? YES ☐ NO ☐
   If YES: Please describe (suspended, expelled, etc.) _____
6. Ever identified with a learning disorder in school? YES ☐ NO ☐

   YES:(check all that apply)Math ☐ Reading ☐ Writing ☐ Speech ☐ Attention ☐ Dyslexia ☐
7. Grades received in past: A☐B☐C☐D☐F☐ Above Average ☐ Average ☐ Below Average ☐

   Current grades received: A☐B☐C☐D☐F☐ Above Average ☐ Average ☐ Below Average ☐ N/A ☐

8. Extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

   _____ _____

   _____ _____

   _____ _____

9. List any special abilities, skills, or strengths:

_____

_____

Please share any cultural, spiritual or religious beliefs (including tribal affiliations) which are important to you:

_____

_____

LEGAL HISTORY

1. Involvement of any legal issues: YES ☐ NO ☐
   If Yes, what for?_____

2. DFS Involvement: YES ☐ NO ☐ Current Case Worker: _____

Relevant Details:

_____

_____

FAMILY HISTORY

1. Have you been raised by anyone other than your biological parents? YES ☐ NO ☐
   If yes, who? _____
2. Please list any family history of mental illness, trauma, substance abuse:

   _____

   _____

3. Any current family issues with alcohol or drugs? YES ☐ NO ☐

   _____

   _____

MEDICAL HISTORY

Do you consider yourself in good physical health? YES ☐ NO ☐

Name of primary care physician: _____

Name of Practice (if one): _____

Address: _____

Phone Number: _____ Fax Number: _____

What was the date of your last physical? _____ UNKNOWN ____

Please mark any of the following medical issues and describe:

- ☐ Vision/hearing problems _____
- ☐ Head trauma/ accidents _____
- ☐ Surgeries _____
- ☐ Allergies _____
- ☐ Disabilities _____
- ☐ Other Medical Conditions _____

Additional information about physical health/medical history relevant to treatment:

_____

_____

_____

PRE-NATAL AND DELIVERY HISTORY

Did your birth mother receive regular pre-natal care? YES☐ NO☐ Unknown ☐

Were there any complications or exposure to alcohol, drugs, cigarettes, other chemicals or trauma during the pregnancy? YES☐ NO☐ Unknown☐
If Yes, please provide details:

_____

_____

_____

Type of Delivery: (circle one) Induced☐ Vaginal☐ C-Section☐ Breech☐ Full Term☐ Premature☐ Unknown☐
If premature, how many weeks? _____

Complications? YES☐ NO☐ Unknown☐
If Yes, please provide details:

_____

_____

Any developmental delays (walking, talking, etc.)? YES☐ NO☐ Unknown☐

_____

_____

Any sensory concerns? YES☐ NO☐

_____

_____

Any major childhood illnesses or hospitalizations? YES☐ NO☐

_____

_____

GENERAL INFORMATION

Please list the five things you would like to do more of and less of in order of priority to you.

	Like to do More Often	Like to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____