Advanced Counseling and Testing Solutions LLC
2121 Oregon Pike, Suite 201
Lancaster, PA 17601
717-208-6599
www.ACTSofLancaster.com

Adolescent Intake Background Data

This questionnaire is to gather important background information on you that will assist us in providing you high quality care. Please answer the following questions to the best of your ability.

Date:_____

Student Name:_____

Date of Birth:_____

Parent or Parents (or Persons completing this form)

Name :_____

Family's Address: _____

Email Address: _____

Telephone Number (s):

Mobile:_____

Home:_____

Work: _____

Insurance:_____ Subscriber:_____

ID Number: _____ Carriers DOB: _____

Briefly state your main concerns regarding this child at home, school and community settings:

_____

_____

_____

_____

Please note any specific questions you would like answered by this evaluation/Assessment:

_____

_____

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Please indicate the outcomes or services you would like to result from this evaluation and or treatment:

_____

_____

_____

_____

FAMILY INFORMATION

Biological Father_____Age_____Highest grade completed_____

Does child live with this parent? Yes_____ No (Explain)_____

Biological Mother_____Age_____Highest grade completed_____

Does child live with this parent? Yes_____ No (Explain)_____

If parents are separated or divorced, please indicate the date of divorce and describe present custody and visitation arrangements:

_____

_____

_____

Primary language spoken at home:_____

Ethnic/Cultural Identification:_____

Does this child speak a second language? Yes_____ No_____
If so, how well does he speak it? Fluently_____ Limited_____

List the names and information requested for all individuals living in the household (include siblings, stepparents, grandparents, etc.)

Name	***Relationship***	***Age***	***Comments***

Are there any siblings living outside the home? Yes_____ No_____

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If yes, please explain and list names and ages: _____

Have any members of your family had *learning or school related problems?* Yes____ No____

If yes, please explain: _____

Have any members of your family had *behavior problems?* Yes_____ No_____

If yes, please explain:_____

_____

List any agencies and/or caseworkers involved with this child or your family:

_____

_____

Please describe any social stressors or family situations that may be affecting this child (e.g. death of family member, divorce, etc.):

_____

_____

DEVELOPMENTAL HISTORY

Was the pregnancy full-term (37 to 40 weeks)? Yes_____ No_____

Was the pregnancy with this child normal? Yes_____ No_____

If no, please explain: _____

Was the labor and delivery normal? Yes_____ No _____

If no, please explain: _____

_____

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Check any of the following that occurred:

___ Induced delivery

___ Forceps

___ Suction

____ Other

____ Medication to ease labor pains: Type:_____

____ Cesarean section

____ Breech delivery

____ Other

Check any of the following that occurred to the infant during or immediately following birth:

Injury during delivery __ Yes __ No Explain:_____

Cord around neck __ Yes __ No Explain:_____

Cardiopulmonary distress __ Yes __ No Explain:_____

Needed oxygen (turned blue) __ Yes __ No Explain:_____

Had an infection __ Yes __No Explain:_____

Birth defects __ Yes __No Explain:_____

Incubation __Yes __No Explain;_____

Was given medications __ Yes __No Explain:_____

Seizures __ Yes __No Explain:_____

Jaundice __ Yes __No Explain:_____

Explain any additional care this child needed: _____

_____

What was this child's birth weight? _____

Rate this child's overall development: Slow_____ Normal_____ Fast_____

Please explain and note any concerns you had with this child as an infant:

_____

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Indicate the age in which this child achieved the following milestones: (estimate if unsure)

_____ Sat alone

_____ Crawled

_____ Walked alone

_____ Ran well

_____ Fed self with spoon

_____ Tied shoes

_____ First Words

_____ Spoke short sentence (2 words together)

_____ Began to read

_____ Toilet trained (day)

_____ Toilet trained (night)

_____ Scribbled with pencil

Do you have any concerns concerning this child's motor or physical development? Yes_____ No_____
If yes, please explain:

_____

_____

Do you have any concerns with this child's speech or language development (e.g. stuttering, articulation difficulties, poor understanding, etc)? Yes_____ No _____

yes, please explain: _____

_____

MEDICAL INFORMATION

How is this child's overall health? Excellent_____ Good_____ Fair_____ Poor_____

Please list any emergency room services, surgeries or hospitalizations this child has received for physical or mental health conditions:

Reason	*Date*	*Age*	*Comments*

Does this child have any vision problems? Yes_____ No_____

If yes, please explain: _____

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Does this child have any hearing difficulties? Yes_____ No_____

If yes, please explain: _____

_____

Please indicate whether or not this child has or has had any of the following conditions:

		Comments
Allergies	Yes____ No__	_____
Asthma	Yes____ No__	_____
Chronic illness (e.g. diabetes, etc.)	Yes____ No__	_____
Seizures/Convulsions	Yes____ No__	_____
Head Injuries	Yes____ No__	_____
Loss of consciousness	Yes____ No__	_____
High fevers (105 degrees or above)	Yes__ __No__	_____
Motor or vocal tics	Yes____ No__	_____
Lead poisoning	Yes____ No__	_____
Dizziness/blurred vision	Yes____ No__	_____
Stomach pain	Yes____ No__	_____
Bladder difficulties	Yes____ No__	_____
Bowel problems	Yes____ No__	_____
Ear infections (how frequent)	Yes____ No__	_____
Broken bones	Yes____ No__	_____
Sleep problems (please describe)	Yes____ No__	_____
Frequent headaches	Yes____ No__	_____

List any medications this child takes on a regular basis:

Medication	***Dosage***	***Reason***

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Explain any side effects this child experiences from the above listed medications:

_____

_____

Who monitors this child's medication (list physician's name and frequency of medication checks):

_____

(please include any physician's name and address that your child currently sees on the permission to release form)

Check any of the following therapies/treatments this child currently receives. If these services were received in the past, write the date next to the treatment.

___ Speech and language therapy
___ Occupational therapy
___ Physical therapy
___ Other:
___ Music therapy
___ Vision therapy
___ Hearing therapy
___ Recreational therapy

Has this child ever received a psychological or psychiatric evaluation? Yes____ No____

If yes, when, by whom, and what was the outcome (diagnosis, treatment, etc.)?

_____

_____

_____

Please attach a copy of the most recent evaluation report to this form

Check any of the following mental health or behavioral health services this child is currently receiving. If the child received these in the past, please list the date next to the service.

___ Inpatient hospitalization
___ Outpatient services
___ Family-based mental health
___ Drug and alcohol services
___ Medication management
___ Partial hospitalization
___ Wraparound services
___ Residential treatment facility
___ MH/MR case management
___ Other:

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EDUCATIONAL INFORMATION

Please list this child's school experiences, including preschool/Head Start:

Grade(s)	*School/City*	*Comments*

Has this child ever repeated or skipped a grade Yes____ No____

If yes, indicate which grade and reasons: _____

_____

Describe this child's academic and/or behavioral strengths at school:

_____

_____

Describe this child's academic and/or behavioral weaknesses at school:

_____

_____

Does the school share similar concerns regarding this child? Yes___ No___

If no, please explain: _____

_____

Does this child presently receive any special services at school? Yes___ No___

If yes, please describe: _____

_____

Has the school listened to your concerns regarding this child? Yes___ No___

If no, explain what you would have liked to be different:_____

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Do you believe this child has made normal educational progress? Yes___ No___

Do you think this child is in need of special education services? Yes___ No___

Has this child had any prolonged absence from school? Yes___ No___

If yes, explain: _____

Does this child like to go to school? Yes___ No___

If no, explain: _____

_____

Does this child have complaints about school? Yes___ No___

If yes, explain: _____

_____

Please provide any additional information regarding this child's educational or school background.

_____

_____

SOCIAL INTERACTIONS

Does this child make friends easily? Yes___ No___

If no, explain: _____

_____

Does this child prefer to play alone? Yes___ No___

If yes, explain: _____

_____

Are this child's friends: Older_____ Same age_____ Younger_____

Do other children seek this child's friendship? Yes___ No___

Describe this child's social interaction skills: _____

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_____

_____

ADDITIONAL INFORMATION

Provide information on this child's interests: _____

_____

List any activities this child dislikes: _____

_____

What types of discipline are used with his child at home ***(indicate effectiveness):***

_____

_____

Has this child been involved in any legal issues (e.g. probation)? Yes___ No___

If yes, please explain: _____

Is this child able to complete age appropriate self-help skills (e.g. toileting, dressing, bathing)? Yes___ No___

If no, please explain: _____

_____

Write any additional comments regarding this child that may assist in this evaluation:

_____

_____

_____

Signature of Parent/Guardian: _____

Date:_____

Relationship to child: _____