**ABRAZO FOSTER FAMILY AGENCY**

**INITIAL INTAKE SUMMARY**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| INTAKE DATE | |  | | | TIME: | | |  | | |  |
|  | | | | | | | | | | | |
|  | | | | | | |  | |  | | |
| PERSON | LAST, First M. | | | | |  |  | |  | DOB |  |
|  | | | | | | | ID No. | |  | | |
|  | | | | | | | | | | | |
| MAILING ADDRESS | | |  | | | | | | | | |
|  | | | | | | | | | | | |
| PHYSICAL ADDRESS | | | |  | | | | | | | |
|  | | | | | | | | | | | |

**Chief Complaint/Statement of Need** (“Quotes” from Person/Parent/Guardian)

**Referral Source, Duration of Complaint, and Presenting Symptoms/Onset**

**Demographics/Background Information**

**Age:** **Gender:**  Male  Female

**Race/Ethnicity:**  Caucasian  Latino  Hispanic  African American  Asian

Native American  Alaska Native  Other (Specify):

**Cultural/Spiritual considerations**:

**Living Arrangements:**

With Family/Significant Other ( Apartment  Single-family dwelling  Multi-family dwelling [duplex, quad, etc.]  Hotel  Shelter)

Homeless (Specify):

Foster Care Placement:  Initial  Multiple (Specify Date[s], Length of Stay[s], and Termination Reason[s]):

Other (Specify):

**Household Members:**

Immediate Family  Extended Family  Non-relatives

Children (Specify age, gender, and relationship to client):

Other/Comments:

**Parents’ Rights/Legal Guardianship:**

N/A

Parental Rights dispute (Specify):

Visitation restrictions (Specify):

Past or present involvement with OCS (the Office of Children's Services); explain:

Identified Legal Guardian and/or Conservator (Name/Contact Information):

**Educational History:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child/Adolescent Educational Assessment** | **Current Educational Setting:** | | | | | | | | | | | | | | |
| N/A | Public | | Private | Boarding | | Alternate | | Home | | | | Charter | |  |
| Other (Specify): | | |  |  | |  | | | |  | | | | |
| **Current Grade Level** | |  | | | **Skipped Grade** | |  | | **Held back grade** | | | |  | |
| **Any testing for an IEP (Individualized Education Plan)?** | | | | | | | | | | | **No** | | **Yes** | |
| If any history of, or current placement in, special education, how many hours per day? | | | | | | | | | | | | |  | |
| **History of learning problems?** | | | | | | | | | | | **No** | | **Yes** | |
| If yes, comment: | | | | | | | | | | | | | | |
| **History of behavioral problems?** | | | | | | | | | | | **No** | | **Yes** | |
| If yes, comment: | | | | | | | | | | | | | | |
| **History of hyperactivity at school?** | | | | | | | | | | | **No** | | **Yes** | |
| **Ever been expelled or suspended from school?** | | | | | | | | | | | **No** | | **Yes** | |
| If yes, reason: | | | | | | | | | | | | | | |
| **School attendance problems?** | | | | | | | | | | | **No** | | **Yes** | |
| If yes, comment: | | | | | | | | | | | | | | |
| **Other education-related concerns:** | | | | | | | | | | | | | | |

**Social History**

**Place of Birth:**

**Siblings:**  N/A or Unknown  No/None Reported  Yes (Specify below):

Age: Gender: Biological: Step: Half: Adopted: Foster:

       M /  F

       M /  F

       M /  F

**Biological Parents:**

Unknown  Together at time of client’s birth  Never married  Married  Separated  Divorced

Remarried  Mother /  Father /  Both Date(s):

Deceased  Mother /  Father /  Both Date(s):

**Relationship with Parents:**

Mother **/**  Stepmother **/**  Adoptive **/**  Foster  Father **/**  Stepfather **/**  Adoptive **/**  Foster

N/A or Unknown  N/A or Unknown

Close / Attached / Connected  Close / Attached / Connected

Turbulent / Strained  Turbulent / Strained

Discordant / Disengaged  Discordant / Disengaged

Highly Conflicted / Dysfunctional  Highly Conflicted / Dysfunctional

**Other Relevant Current Family Dynamics:**

**History of trauma:**  None Reported  Neglect  Physical / Verbal Abuse

Sexual Abuse  Rape  Domestic Violence

Other (Specify):

**Family Psychiatric History:**

History of Abuse (Specify history of abuse or trauma):

**N/A** **Mother** **Father** **Siblings** **Extended Family**

History of Completed Suicide (Select all that apply):

If yes, specify:

History of Mental Illness/Problems?  Unknown  No  Yes (Specify):

**Past Medical History/Developmental History**

**Prenatal:**  Unremarkable/Within normal limits  Other (Specify):

**Developmental:**  Unremarkable/Within normal limits  Other (Specify):

**Illness/Injury:**  No/none reported  Yes (Specify type/date):

**Health Record**

Have you experienced/been diagnosed with any medical issues and if so when?

Currently under MD care?\_\_\_\_(Y/N) Physician: Phone Number Referral Made:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Need for Assistive Technology*.specify*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medical issues not mentioned?\_\_\_\_\_\_(Y/N) (problems with sleep patterns, eating habits, eating disorders)

Explain

**Hospitalizations/Surgeries:**  No/none reported  Yes (Specify type/date):

**Drug Allergies:**  No/none reported  Yes (Specify):

**Primary Care Provider:**  No/none reported  Yes (Specify):

Last medical/primary care clinic office visit:  Within the last month  2 to 3 months ago  3 to 6 months ago

6 to 12 months ago  Over a year ago  Not reported

**Non-Psychiatric Medications:**

Is client currently prescribed, or taking, non-psychiatric medication?  No/none reported  Yes (Indicate below):

|  |  |  |
| --- | --- | --- |
| Non-Psychiatric Medications: | Dose: | Frequency: |
|  |  |  |
|  |  |  |

**Psychiatric Medications:**

Has client previously been prescribed, or taken, psychiatric medications?  No/none reported  Yes

Is the client currently prescribed, or taking, psychiatric medication?  No/none reported  Yes

If yes to either of the above questions, indicate below:

|  |  |  |  |
| --- | --- | --- | --- |
| Current: | Psychiatric Medications: | Dose: | Frequency: |
|  |  |  |  |
|  |  |  |  |

Medications prescribed were to alleviate symptoms of:

N/A  Anxiety  Mood Lability  Confusion  Depression  Attention difficulties

Sleep disturbance  Obsessive/Compulsive thoughts and behaviors  Other (Specify):

Were client’s symptoms reduced?  N/A  No  Yes  Unknown

**Past Psychiatric History**  Section Not Applicable

**Prior treatment / Treatment dates**

Inpatient hospitalization:

Outpatient therapy:

Psychological testing:

Psychopharmacology:

Other: (Specify)

Was previous treatment helpful?  Undecided  No  Yes

**Prior Psychiatric Diagnosis:**

History of psychiatric diagnosis?  Client uncertain  No  Yes (Select all that apply):

Mood Disorder/Bipolar I/II  Depression  Anxiety

Panic Disorder  Posttraumatic Stress Disorder  Attention-Deficit/Hyperactivity Disorder

Oppositional Defiant  Conduct Disorder  Other (Specify):

## Mental Status Examination

Appearance/Dress:NeatCasualSloppyAdequateAppropriateInappropriate

Grooming/Hygiene:AppropriateMeticulousPoorUnkemptB.O.Dirty

Eye Contact:AverageDecreasedIncreased

Motor Behavior/Posture:NormalAgitatedPacingHyperactiveRetardedTics/TwitchesRigid PostureBizarrePostureCatatonic Syndrome

Level of Consciousness:AlertUnresponsiveOriented x 3Disoriented

Behaviors/Attitudes:CooperativeAttentiveCombativeAggressiveHostileAngryGuardedEvasiveDefensiveSuspiciousUncooperativeSeductiveWithdrawnPassiveFrightenedApatheticOppositionalPreoccupied

Mood:EuthymicEuphoricDepressedAnxiousExpansiveIrritable

Affect:StableConstrictedFlatLabileCongruent with MoodInappropriateBluntedFearful

Speech:NormalPressuredSlowedSlurredSoftMuteRapidLoudRamblingMumblingMonotone

Thought Content/Process:NormalDelusions **(**Persecutory BizarreGrandioseReferenceControlNihilistReligious**)**BlockingFlight of IdeasLoose AssociationsPoverty of contentObsessionsCompulsionsPhobiasGuiltThought insertionThought broadcastingHallucinations **(**AuditoryVisualTactileOlfactoryGustatory [taste]Other**)**IllusionsDepersonalizationDerealization

Attention Span:Not Tested **(**Serial 7’s, Digit Span [Adults]**)**NormalShortDistractibleIntactImpairedGrossly Impaired

Memory:Not Tested **\_\_\_\_\_** of 3 Objects at 5 Minutes [Adults]: Normal Deficits in memory? Immediate Short-Term Long-Term Digits forward/reverse (if applicable):

Insight:GoodFairPoorAbsent

Judgment:GoodFairPoorAbsentAt Risk

Intentional Self-Injury:NoYesSpecify frequency and severity:

SuicideIdeationPlanMethodTimeAttemptedPreviousNo Risk at Present

Current Risk Level:No risk at presentLowModerateHigh

Suicide Summary:

**Three wishes** (Children)**:**

**Strengths and Resources**

**Needs**

**Abilities**

**Preferences**

**Impression/Assessment/ Interpretive Summary** (Review of symptoms leading, and list of criteria used, to develop diagnosis; strength/support network; complicating factors, including at risk of out-of-home placement or institutionalization; discussion and resolution of any differences in diagnosis,)

**Problem List** (impact on functioning by mental health symptoms or alcohol/drug use)

**DSM-IV Diagnosis**

|  |  |  |  |
| --- | --- | --- | --- |
| AXIS I: | Primary |  |  |
|  | Secondary 1 |  |  |
|  | Secondary 2 |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| AXIS II: | Primary |  |  |
|  | Secondary 1 |  |  |
|  | Secondary 2 |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| AXIS III: | Primary |  |  |
|  | Secondary 1 |  |  |
|  | Secondary 2 |  |  |

|  |  |  |
| --- | --- | --- |
| AXIS IV |  | Problems with primary support group:  *Specify*: |
|  |  | Problems related to the social environment*.*  *Specify*: |
|  |  | Educational problems*.*  *Specify*: |
|  |  | Occupational problems*.*  *Specify*: |
|  |  | Housing problems.  *Specify*: |
|  |  | Economic problems.  *Specify*: |
|  |  | Problems with access to health care services.  *Specify*: |
|  |  | Problems related to interaction with the legal system/crime.  *Specify* |
|  |  | Other psychosocial andenvironmental problems.  *Specify*: |

|  |  |  |  |
| --- | --- | --- | --- |
| AXIS V: | GAF: Present: |  |  |

**Prognosis, Medical Necessity, Recommended Services, and Anticipated Discharge Date**

**Prognosis:**

Poor

Guarded due to chronicity of problem and/or treatment non-compliance

Good with consistent adherence to recommended treatment plan

**Recommended Services:**

**Anticipated Discharge Date:**

|  |  |  |
| --- | --- | --- |
| Review Signature |  | Date |