Exceptional Student Education
Programs for Students with Emotional/Behavioral Disabilities
Clinical Services - Intake Form

Clear Form

School Name: _____ Interviewer: _____ Date: _____

A. Student Information:

Interviewee: _____ Student Name: _____ Student ID #: _____

Address: _____ Phone #: _____

Grade: _____ DOB: _____ Age: _____ Response Style: ☐ Internal ☐ External

Legal Guardian: _____ Relationship/Agency: _____

B. Living Arrangements:

1. Please list names of those currently living in the home with student:

Name	Relation	Age/Grade	School	Occupation

2. Home Situation:

☐ House ☐ Apartment ☐ Other: _____ Number of Bedrooms: _____

Comments: _____

C. Family Dynamics:

1. Parent Contact: ☐ Both parents ☐ Mother ☐ Father
2. Who primarily has raised you? _____
3. How are you disciplined at home? _____
4. What are your responsibilities at home? _____
5. Current stressors at home: _____
6. To whom do you go when you need help or to talk? _____
7. How do you get along with your family? _____
8. What kind of things do you and your family argue about? _____
9. What do you do for fun? _____
10. Legal Involvement:

Child: ☐ DCF ☐ DJJ ☐ Other Comments: _____

Mother: ☐ DCF ☐ DJJ ☐ Other Comments: _____

Father: ☐ DCF ☐ DJJ ☐ Other Comments: _____

D. Presenting Information:

1. Why are you in this program? _____

2. What do you need to get out of this program? _____
3. What behaviors get you in trouble? _____
4. What would you like to gain from counseling? _____

E. Medical History:

1. Name of Pediatrician: _____ Phone #: _____
2. Allergies: ☐ No ☐ Unknown ☐ Yes Specify: _____
3. Head injury? ☐ No ☐ Unknown ☐ Yes ☐ Open ☐ Closed When: _____
4. Loss of Consciousness? ☐ No ☐ Yes How Long? _____
5. Other Medical Concerns/Hospitalizations: _____

F. Mental Health Services:

Outpatient Services	Agency	Provider Name	Active	Date of Last Visit
Case Manager			Y / N	
Therapist			Y / N	
Psychiatrist			Y / N	
(Other/Additional)			Y / N	
(Other/Additional)			Y / N	

Inpatient Services	Agency/Hospital	Date of Service	Presenting Problem
Baker Act			
Psychiatrist Hospitalizations			
(Other/Additional)			
(Other/Additional)			

G. Current Medication ☐ **N/A**

Medication	Dosage	Frequency	Purpose

H. Past Medication ☐ **N/A**

Medication	Dosage	Frequency	Purpose

MIDDLE SCHOOL/HIGH SCHOOL INSERT

I. Current School Information

1. ☐ Day ☐ Night ☐ Both: _____
2. ☐ Diploma ☐ Regular ☐ Special: _____
3. ☐ Inclusion ☐ No ☐ Yes ☐ Special: _____
4. Career Goals: _____
5. School Goals: _____

6. After school group/club involvement:

J. Employment History:

1. Employment: ☐ No ☐ Yes; ☐ Part time ☐ Full Time Where:_____

_____

K. Social:

1. Describe your friends:_____

2. Personal relationships: ☐ boyfriend / girlfriend comments: _____

3. Weekend / After School Activities: _____

4. What Do You Do for Fun?_____

	How often	Where / With whom	When did you start	Kind / type
Smoke cigarettes				
Drink alcohol				
Illegal Drugs				

Comments: