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