Native American LifeLines, Inc.
106 West Clay Street
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NAL Child/Adolescent Intake Form

Date of Intake: Choose intake date. Interviewer: Staff Interviewer.

Name: Last, First Middle Social Security Number: SSN Date of Birth: DOB

Address: Address Number and Street City, State and Zip Resides with: (if applicable)

Phone Number: Cell Number Home Number Work Number Email Address: Enter info

Health Insurance: Choose Coverage MA Number (if applicable): Enter Info

Age: Age Sex: Sex Ethnicity: Select Ethnicity Race: Choose an item.

Sexual Orientation: Enter info Gender Identity: Enter Info Preferred Pronouns: Enter Info

Religion: Select Religion Tribal Affiliation: Enter Info

Tribal ID Card: ☐Yes ☐No Blood Quantum: Enter Info

Emergency Contact Information

Emergency Contact: Person's Name Relationship to Client Phone Number: Phone Number

Emergency Contact's Address: Address Number and Street same as above City. State and Zip

Responsible Parties

Name(s) of Person(s) Responsible for Child's Care (include step-parents, foster parents, inc.)

Name: Last, First Middle Relationship to Client: Relationship to Client Date of Birth: DOB
Address: Address Number and Street City, State and Zip
Phone Number: Cell Number Home Number Work Number

Name: Last, First Middle Relationship to Client: Relationship to Client Date of Birth: DOB
Address: Address Number and Street City, State and Zip
Phone Number: Cell Number Home Number Work Number

Name: Last, First Middle_Relationship to Client: Relationship to Client_ Date of Birth: DOB
Address: Address Number and Street same as City, State and Zip
Phone Number: Cell Number Home Number Work Number
If adopted, at what age: Enter Info Foster since Enter Info

Comments about custody and visitation (if applicable): Enter Info

Presenting Problem(s)

Referred by: Enter Referral Name Referral Source: Referral Source
Presenting Problem(s): Enter Presenting Problem(s)
History of Presenting Problem(s): Enter History of Presenting Problem(s)

Medical History

Pregnancy
Was prenatal care received during the pregnancy? Yes ☐ No ☐
If yes, how many months was prenatal care received? Enter Info
Delivery:
Normal ☐ Breech ☐ Cesarean ☐ Transectional ☐
Full-term ☐ Premature ☐ If premature, number of weeks Enter Info
Birth Weight: Enter Info

Problems at birth (for example: oxygen, blood transfusion, placed in an incubator, etc.):
Enter Info

Which substances were used during the pregnancy:

Alcohol	Yes ☐ No ☐
Cigarettes	Yes ☐ No ☐
Benzodiazepines (Valium, Ativan, & Clonazepam)	Yes ☐ No ☐
Cannabis	Yes ☐ No ☐
Opiates (OxyContin, Percocet, & Heroin)	Yes ☐ No ☐
Hallucinogens (LSD, PCP, etc.)	Yes ☐ No ☐
Methamphetamine	Yes ☐ No ☐

Current Medical History
Current weight: Enter Weight Current height: Enter Height BMI: Enter BMI
Are there any foods that you limit or do not give this child? Yes ☐ No ☐

Number of head injuries / concussions: #
Significant childhood illnesses and/or injuries: Enter Illnesses and/or Injuries

Allergies: Enter Allergies
Current Medications (name, dosage, & instructions): Enter Current Medications
Child's Doctor: Enter Info
Date of last physical exam: Enter Info
Vision problems? Yes ☐ No ☐ X Hearing problems? Yes ☐ No ☐
Dental problems? Yes ☐ No ☐
(list) Enter Info
Does anyone in the household smoke? Yes ☐ No ☐
Has your home been tested for lead? Yes ☐ No ☐

Developmental History

State approximate age when child did the following:
Walked alone Age Said first word Age Used 2-word phrases Age

In the first two years, did your child experience:
☐ Separation from mother ☐ Out of home care ☐ Disruption in bonding
☐ Depression of mother every other day ☐ Chronic pain ☐ Chronic Illness ☐ Parental Stress

About how many hours does this child watch TV, videos, etc. per day Enter Info15 mins/day

Any previous testing (school/psychological)? Yes ☐ No ☐
Whom/where Enter Info when Enter Info

Any previous or current involvement with other agencies (CPS, mental health treatment, substance use treatment, tutoring, group home, hospitalizations, special needs, etc.)
Practitioner/Agency Select Type From/To Diagnoses/Problems
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Parent's Information and Family of Origin

Mother's Name: Mother's Full Maiden Name Place of Birth: Place of Birth
Mother's Occupation: Mother's Occupation
Father's Name: Father's Full Name Place of Birth: Place of Birth
Father's Occupation: Father's Occupation
Number of brothers: # Number of sisters: # Place in birth order: #
Who resided in the home? Type home occupants and relationships

Siblings

Name	Sex	Age	Relation to client

How is your child disciplined? Please list each method and frequency of use Enter Info

Do either of the child's biological parents have any history of substance use? Yes ☐ No ☐
Which parent(s) Enter Info
Type of substance(s): Enter Info
List any history of mental illness or addiction in immediate or extended family (Ex: Depression, Anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):
Enter Info

*PHQ-9 Modified for Adolescents (PHQ-A) Ages 11-17**

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days?

	0 Not at all	1 Several days	2 More than half the days	3 Nearly every day	
Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐	
Little interest or pleasure in doing things?	☐	☐	☐	☐	
Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐	
Poor appetite or overeating?	☐	☐	☐	☐	
Feeling tired of having little energy?	☐	☐	☐	☐	
Feeling bad about yourself - or that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐	
Trouble concentrating on things like school work, reading or watching TV?	☐	☐	☐	☐	
Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐	
Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐	**Grand Total:**
Totals:	0	Total 1s	Total 2s	Total 3s	Grand Total

1-4: Minimal Depression, 5-9: Mild Depression, 10-14 Moderate Depression,
15-19 Moderately Severe Depression, 20-27 Severe Depression

Academic History

1. Present School: Enter Info Grade: Enter Info Teacher: Enter Info
2. What grade(s) if any, has child repeated? Enter Info
3. Is child in special education services? Yes ☐ No ☐ What kind? Enter Info
4. Please describe academic or other problems your child has had in school
Enter Info

Life stressors / Trauma History

Has your child experienced the death of a close family member or friend?
Has your child known anyone who has died of an overdose? Yes ☐ No ☐
Has your child known anyone who has completed suicide? Yes ☐ No ☐
Has your child been verbally abused? Yes ☐ No ☐ Suspected ☐ Specify Enter Info
Has your child been physically abused Yes ☐ No ☐ Suspected ☐ Specify Enter Info
Has your child been sexually abused? Yes ☐ No ☐ Suspected ☐ Specify Enter Info
Has child witnessed domestic violence? Yes ☐ No ☐ Suspected ☐ Specify Enter Info
Other stressors or traumas? Enter Info

Any additional comments or information that would be helpful to us?_Enter Info

Legal History

Number of arrests: Select Number Charges: Enter info

Incarcerations: Enter info Currently on Probation or Parole? ☐Yes ☐No

PO Name and Contact Information Enter info

Impression:

Diagnosis (DSM V):

Diagnosis	ICD – 10 Code

Client Signature _____ Date of Birth _____ Date _____

Parent/Guardian Signature _____ Date of Birth _____ Date _____

Staff Signature	Position Title	Date