



518 28 Road, Suite B-102 • Grand Junction, CO 81501  
(970) 985-2736 • www.CCCGJ.com • info@cccgj.com

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## YOUTH INTAKE FORM

**Date:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_

**Name :** \_\_\_\_\_

**First**

**Middle**

**Last**

**Family Information:**

**Guardian or Foster Parent:** \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Biological Mother:** \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Biological Father:** \_\_\_\_\_

Address/City/State/Zip (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

What is the reason for your visit? What can I help you with?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Who were you referred by?:**

- |   |   |
|---|---|
| <input type="checkbox"/> Self-referral                  | <input type="checkbox"/> Individual (other adult or relative) |
| <input type="checkbox"/> Street Outreach                | <input type="checkbox"/> Dept. of Human Services              |
| <input type="checkbox"/> Residential Program            | <input type="checkbox"/> Hotline                              |
| <input type="checkbox"/> Other Public Agency or Program | <input type="checkbox"/> Juvenile Justice                     |
| <input type="checkbox"/> Law Enforcement/Police         | <input type="checkbox"/> Religious Organization               |
| <input type="checkbox"/> Mental Hospital                | <input type="checkbox"/> School Name: _____                   |
| <input type="checkbox"/> Other Private Organization     | <input type="checkbox"/> Other: _____                         |

Referral Source Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_



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**Last Grade Completed:**

- |  |  |
|--|--|
| <input type="checkbox"/> Less than Grade 5 | <input type="checkbox"/> GED                                       |
| <input type="checkbox"/> Grades 5-6        | <input type="checkbox"/> Some College                              |
| <input type="checkbox"/> Grades 7-8        | <input type="checkbox"/> School Program Does Not Have Grade Levels |
| <input type="checkbox"/> Grades 9-10       | <input type="checkbox"/> Do Not Know                               |
| <input type="checkbox"/> Grades 11-12      |  |

**School Status:**

- |   |   |
|---|---|
| <input type="checkbox"/> Attending school regularly | <input type="checkbox"/> Attending school irregularly |
| <input type="checkbox"/> Dropped out                | <input type="checkbox"/> Suspended                    |
| <input type="checkbox"/> Expelled                   | <input type="checkbox"/> Graduated High School        |
| <input type="checkbox"/> Don't Know                 |   |

**Name of School Attending:** \_\_\_\_\_ **Phone Nbr** \_\_\_\_\_

**Are you now or have you been in other programs? (State child welfare agency, public juvenile justice system)**

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Where & When? \_\_\_\_\_

Number of months (1-12): \_\_\_\_\_

Number of years (if over 12 months, check one):

- 1-2
- 3-5
- More than 5

Case Manager: \_\_\_\_\_ Parole Officer: \_\_\_\_\_

Been asked to leave other programs? \_\_\_\_\_ If yes, why? \_\_\_\_\_



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Youth ever accused/convicted of sexual perpetration? \_\_\_\_\_ **(If yes, explain)** \_\_\_\_\_

Meds? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Danger to self or others? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Suicidal ideation or attempts? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Duty to warn? \_\_\_\_\_ If yes, who contacted \_\_\_\_\_ Time/Date \_\_\_\_\_

Are you employed? \_\_\_\_\_ If yes, where? \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Address of employer \_\_\_\_\_ City \_\_\_\_\_

Schedule of hours currently working \_\_\_\_\_



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## HISTORY OF PSYCHOLOGICAL COUNSELING OR PSYCHIATRIC HELP

Please check all that apply.

Method	When	Where	What were the issues?
Individual			
Group			
Marriage			
Hospitalization(s)			

List any health problems for which you are currently receiving treatment: \_\_\_\_\_

\_\_\_\_\_

Medication(s): \_\_\_\_\_

\_\_\_\_\_



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## FAMILY HISTORY

Date: \_\_\_\_\_ Name: \_\_\_\_\_

### History in the Family:

Mental Illness in family \_\_\_\_\_

Substance Abuse in family \_\_\_\_\_

Domestic Violence in family \_\_\_\_\_

Sexual Abuse in family \_\_\_\_\_

Physical Abuse in family \_\_\_\_\_

Neglect in family \_\_\_\_\_

Suicidal Attempt(s) in family \_\_\_\_\_

Suicide in family \_\_\_\_\_

Custody Issues \_\_\_\_\_

### History of Self:

Self-Harm to Self (list methods) \_\_\_\_\_

Suicidal Attempt Self \_\_\_\_\_

Neglected as a Child \_\_\_\_\_

School Currently Enrolled \_\_\_\_\_

School History of being Expelled \_\_\_\_\_

School Behavior \_\_\_\_\_

Surgeries \_\_\_\_\_

Accidents \_\_\_\_\_

Age 0 – 5: Separation from mother \_\_\_\_\_

Age 0 – 5 Hospital stays \_\_\_\_\_

Strengths \_\_\_\_\_

Interests/Hobbies \_\_\_\_\_

Supports \_\_\_\_\_

Family Member Closest to \_\_\_\_\_



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Circle Any of the following which are currently causing you difficulty:

- |               |                   |                |           |
|---------------|-------------------|----------------|-----------|
| Anger         | Health            | Career choices | Parenting |
| My Past       | Dating            | Hopelessness   | Food      |
| Anxiety       | Sexual Problems   | Marriage       | Religion  |
| Nightmares    | Panic Attacks     | Concentration  | Finances  |
| Phobia        | Grief             | Work           | Headaches |
| Assertiveness | Suicidal thoughts | Energy         | Abuse     |
| Addiction     | Parents           | Sleep Trouble  | Violence  |
| Divorce       | Hearing Voices    | Guilt          | Sadness   |
| Self-Control  | Depression        | Step-family    | In-laws   |
| Cutting       | Obsessiveness     | Legal Issues   |           |

**OTHER AREAS**
