



**Youth Intake Form**

<b>Name:</b>		<b>DOB:</b>		<b>Case #:</b>			
<b>Date(s) of Intake:</b>							
<b>Accompanied by:</b>			<b>Relationship:</b>				
<b>Informant Name</b>		<b>Relationship</b>		<b>Phone &amp; Email</b>			
Additional Sources of Information:					Interpreter Used		
<b>Presenting Concern</b>							
<b>History of Present Concern</b>							
<b>Youth's Strengths</b>							
<b>Youth's Support System</b>							
<b>Expectations for Treatment</b>							
<b>Somatic Functioning</b>							
<b>Sleep</b>	unremarkable	hypersomnia	insomnia:	initial	middle	early awakening	other:
<b>Weight</b>	unremarkable	loss 1-10 lbs	loss 10+ lbs	gain 1-10 lbs	gain 10+ lbs	other:	
<b>Appetite</b>	developmentally appropriate		increased	decreased	other:		
<b>Energy/Libido</b>	developmentally appropriate		increased	decreased	other:		





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Medications		unknown	does not take medication	
Medication/dose/frequency	Reason	Last Dose	Compliant	
			Y	N
			Y	N
			Y	N
<b>Relevant Social History</b>				
<b>Legal History</b>				
Legal Issues: <input type="checkbox"/> none <input type="checkbox"/> restraining order <input type="checkbox"/> charges <input type="checkbox"/> wayward <input type="checkbox"/> other:				
Describe:				
<b>School Information</b>				
School:		Decline in academic performance?		
Grade:	Sp. Ed:	N	Y	N Y
Describe:				
<b>Relevant Social Functioning</b>				
<b>Relevant Developmental History and Early Childhood Issues</b>				



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Risk/Safety Assessment				
Behaviors	No hx	Active	Past hx	Describe
Suicidal ideation/gestures				
Homicidal ideation/gestures				
Self-injurious behavior				
Assaultive (identify targets)				
Sexualized behavior				
Elopement				
Fire setting				
Substance use/abuse*				<i>Substances, amount, last use, consequences, etc.:</i>
Other risk behaviors:				
Mental Status Examination				
<b>Appearance/Behavior:</b> oriented: person place time				
<b>Mood/Predominant Emotion States:</b> elation fearful sad angry anxious shame curious euthymic				
<b>Thought Process:</b> WNL linear circumstantial tangential loose flight of ideas racing thoughts blocking slowed unable to assess				
<b>Perception:</b> unremarkable hallucinations flashbacks disassociation				
<b>Insight/Self-Awareness:</b> unremarkable fair poor developmentally appropriate other:				
<b>Psychomotor:</b> unremarkable hyperactivity agitated hypoactive tics tremor abnormal movements repetitive behavior stereotyped behavior impaired coordination: fine motor gross motor				
<b>Affect:</b> WNL dysphoric labile intense flat restricted situationally inappropriate				
<b>Thought Content:</b> unable to assess developmentally appropriate fears guilty dreams/nightmares inadequate hopeless worthless delusions obsessions				
<b>Judgment/Reason:</b> unremarkable fair poor developmentally appropriate				
<b>Speech/Language:</b> unremarkable pressured limited expression loud soft hypotalkative hypertalkative mute limited comprehension incoherent nonverbal articulate				
<b>Emotion Regulation:</b> WNL over controlled under controlled				





Fairfax County System of Care Office  
Short Term Behavioral Health Service for Youth

### Statement of Understanding

You have chosen to receive Short-Term Behavioral Health (STBH) Services for Youth funded through the Fairfax County System of Care Office and provided by their approved providers. STBH services may include assessment and referral or brief counseling. The STBH provider will work with you to clarify the problem, identify choices, and develop an action plan. You may receive up to eight sessions total, to include an assessment, counseling sessions, and wrap-up closing session. System of Care staff are available to answer any questions you may have about the program and STBH providers are available to respond to your calls and will advise you of their after-hours contact policy.

#### Fees

These services are provided at no direct cost to you or your family. The System of Care Office pays for these services. However, if you need longer-term counseling or a specialized service, your STBH provider will assist in locating a resource or service in the community. **It is your responsibility to pay for services provided by any resources outside the STBH program.** (If you have health insurance, your insurance benefit plan may cover some of the cost. **Check with your benefits representative before services are provided by outside resources.**)

#### Confidentiality

The STBH Services program will maintain confidential records of your contact.

No one will reveal information concerning your use of this service to anyone outside the program except as follows: 1) you consent in writing; 2) life or safety is seriously threatened; 3) disclosure is required by law; or 4) your STBH provider refers you to benefits-covered treatment and the claims payer requires information. In addition, your STBH provider will disclose information and records to the System of Care Office as needed for coordination of STBH services, quality assurance, or payment.

I, (print parent name) \_\_\_\_\_, understand this form, including the confidentiality of the STBH Service and the limitations to confidentiality, and accept it as the terms of my participation in the program. As an STBH Service for Youth consumer, I also understand that I may request written information describing the System of Care Office's confidentiality policy and the STBH Service provider's confidentiality policy.

**I understand that there may be a no-show fee charged by the STBH Service provider.**

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Youth Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**STBH Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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**Discharge Summary**

Youth's Name:

Case #:

**STATUS OF PROGRESS:**

**Target Problem(s)**

- Deteriorated
- No change
- Minimal improvement
- Moderate improvement
- Significant improvement
- Not addressed/Plan changed
- Unknown: \_\_\_\_\_

**REASON CASE CLOSED:**

- Goals met/Client satisfied
- Client dropped out against advice
- Client referred
- Client utilized all available sessions
- Other: \_\_\_\_\_

**REFERRALS: (check all that apply)**

**Client referred to:**

- Substance use treatment
- Mental health treatment
- Provider within insurance plan
- Community Services Board
- Private non-profit behavioral health provider
- Other private provider
- Other: \_\_\_\_\_
- No referral

**Level of care:**

- Community resources
- Outpatient
- Intensive inpatient
- Partial hospitalization
- Inpatient
- Other: \_\_\_\_\_

**Provider/Facility/Resource Information referred to:**

- Name:**
- Address:**
- Phone:**

**FOLLOW-UP:**

Did client receive services for which they were referred?      Yes      No

Number of sessions attended by youth:

Summary/Comments: