Adolescent IOP Intake Assessment

Date:_____________ Employee:__________________________

To be completed with client and parent/guardian

Client Name____________________________ Date of Birth:_______________

Address________________________________ City_______________State_______Zip __________________

Home Phone(____)__________________Current Grade _________ School______________________________

Emergency Contact ____

Name/ Relationship/Phone

Parent/Guardian 1 Name____________________ Date of Birth:_________ Relationship to client:____________

Address ____________________________ City____________State____Zip _______ Employer ______________

Cell Phone (____)_______________ Work Phone (____)_______________ Email: _________________________

Parent/Guardian 2 Name____________________ Date of Birth:_________ Relationship to client: ____________

Address ____________________________ City____________State____Zip _______ Employer ______________

Cell Phone (____)_______________ Work Phone (____)_______________ Email: _________________________

Billable Party Name (If different than Client Name listed above):____

Address (If Different)___________________________ City_______________State_______Zip________________

Cell Phone (____)_______________ Work Phone (____)_______________ Email: __________________________

Please describe the concerns you have and the reason(s) for requesting services:

____

____

Communication of Private Mental Health Information: There may be times when Root Center staff needs to leave you a voicemail in regards to appointment times, account questions, or other reasons relating to your care. Please inform us if you have a preferred number for messages. When responding to client initiated contact, we will respond using the requested method you specify.

Minor/Child Consent: I have legal authority to do all things necessary with regards to seeking therapy/counseling for my child(ren). I give my permission of treatment for my child(ren) to receive therapy/counseling from Root Center for Advanced Recovery, I also acknowledge that the above information is correct.

____

Parent/Guardian Signature Printed Name Date

____

Parent/Guardian Signature Printed Name Date

To be completed with the client

Client Name: _______________________________ Employee:___________________________

Marital Status of Parents ____Married ____Remarried ____Single ____Separated ____Divorced

____Divorced/Single ____Divorced/Dating If Divorced: date(s) final ____________________

Age of child at separation(s)_________________

1. Who do you talk to when you need positive, emotional support?

_____Mother _____Father _____Adult Relative _____Friend _____Sibling _____Teacher

_____Other____

2. Have you ever been involved on any of the following services?

_____Support Groups _____Treatment Program _____Mental Health Counseling _____Anger Mgmt. Classes

_____Family Counseling _____Other__________________

3. Please list any physical disabilities you may have.____

____

4. Please list any medications you are currently be taking and for what reason.

Medication(s)____Reason______________________________________

5. Please list any health concerns you have. ____

____

____

6. Briefly describe your current school experience (i.e. relationship with teachers, grades and school work, concentration, relationship with peers, etc).

____

____

7. Briefly describe how you are currently functioning at home (i.e. relationship with sibling/s, relationship with

parent/s, etc). ____

8. Please list the members of your current household (In order of age).
Name/Age/Relationship (i.e. mother, step-father, child #)

____

____

____

____

____

9. Briefly describe your current peer relationships (in and outside of school).

____

____

10. What substances have you used in your lifetime and over the past 30 days?

Substance	Age of first use	Current Use Y/N	Type	Frequency	Length of use	Route of Use O-Oral, n-Nasal, IV-IV, S-Smoke, Other
Alcohol						
Amphetamines						
Barbiturates						
Benzodiazepines						
Cocaine						
Cough Medicine						
Inhalants						
Opioids (Percocet, Percodan, Darvocet, Oxycodone, Morphine, Fentanyl)						
Marijuana						
MDMA (Ecstacy) (Molly)						
Methamphetamine						
Nicotine						
Synthetic Marijuana						
Other						

11. How would you describe your mood most days?

[ ]Happy [ ]Sad [ ]Indifferent [ ]Angry [ ]Anxious [ ]Irritable [ ]Other

12. Have you ever had treatment for your mood? [ ] Yes [ ] No, If yes please explain:_____________________

13. Do you have any current suicidal ideations [ ] Yes [ ] No, If yes: please explain:________________________

14. Have you ever attempted suicide? [ ] Yes [ ] No, If yes please explain:______________________________

15. Have you ever been arrested or had legal issues? [ ] Yes [ ] No, If yes please explain:_________________

16. What do you believe are the greatest challenges for you currently?

____

____

____

17. What are your goals for treatment?

18. What are your strengths?

Formulation (Narrative of above information and recommendation for treatment):

Patient meets the criteria for IOP based on the following:

<u>The above patient has been assessed meets the Criteria for IOP Admission as outlined below:</u>
Criteria for admission to IOP includes:

- _____The individual is assessed as meeting the diagnostic criteria for a Substance-Related Disorder (including Substance Use Disorder or Substance-Induced Disorder).

- _____IOP Program is advisable for an individual who (a) has met the essential treatment objectives at a more intensive level of care (high likelihood of relapse without close monitoring and support, or an increase in Substance use Sx) and (b) requires the intensity of services provided at the IOP Level (i.e. poor treatment engagement, requires structured program, unsupportive environment).

- _____IOP program is advisable when the services provided at the OP Level have proved insufficient to address the individual's needs.