

**Adolescent Alternatives  
Admission Assessment and Screening**

**Client Record #** \_\_\_\_\_  
**Date Current Active in Mental Health System**

\_\_\_\_\_  
**Date admission to HRI/Other Treatment**

\_\_\_\_\_  
**Screening Date** \_\_\_\_\_  
**Discharge Date** \_\_\_\_\_

**Name** \_\_\_\_\_  
**Medicaid#** \_\_\_\_\_  
**Insurance CO** \_\_\_\_\_

**Home Phone#** \_\_\_\_\_  
**Other Phone#** \_\_\_\_\_  
**Sex** \_\_\_\_\_ **Race** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**ED. Level** \_\_\_\_\_ **SSN#** \_\_\_\_\_  
**Birth Place** \_\_\_\_\_

**Home Address** \_\_\_\_\_  
\_\_\_\_\_  
**City** \_\_\_\_\_  
**State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Emergency Contact Person** \_\_\_\_\_  
**Phone #** \_\_\_\_\_  
**Mother's Name** \_\_\_\_\_  
**Father's Name** \_\_\_\_\_

**Next of Kin** \_\_\_\_\_  
**Phone #** \_\_\_\_\_  
**Address** \_\_\_\_\_  
\_\_\_\_\_  
**City** \_\_\_\_\_  
\_\_\_\_\_  
**State** \_\_\_\_\_ **Zip** \_\_\_\_\_

<b>CLIENT:</b>	<b>RECORD NO.</b>
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**APPLICATION FOR SERVICE**

To (Name of Agency): \_\_\_\_\_

From (person/agency making application) \_\_\_\_\_

This complete application, with supporting documentation, provides the information necessary to decide whether to admit the child. If the child is admitted, the documents relating specifically to admission will be required. If additional space is needed for any question, add an extra sheet or write on the back of the application; be sure to give question number for reference.

**I. FAMILY INFORMATION**

**CHILD:**

- 1. Name: \_\_\_\_\_  
Last First MI
- 2. Prefers to be called: \_\_\_\_\_
- 3. Date of Birth: \_\_\_\_\_
- 4. Verified? Yes ( ) No ( )
- 5. Sex: \_\_\_\_\_
- 6. Race \_\_\_\_\_
- 7. Social Security No. \_\_\_\_\_
- 8. Place of Birth: (City) \_\_\_\_\_  
(County): \_\_\_\_\_ State or Country: \_\_\_\_\_
- 9. Currently living with: Biological Parent (s) \_\_\_\_\_ Relative \_\_\_\_\_ Foster Family \_\_\_\_\_  
Other (Specify) \_\_\_\_\_

**BIOLOGICAL PARENTS:**

- 10. Father's Name: \_\_\_\_\_  
Last First MI
- 11. Social Security No. \_\_\_\_\_
- 12. Address: \_\_\_\_\_
- 13. Phone No. \_\_\_\_\_
- 14. Date of Birth: \_\_\_\_\_
- 15. Date of Death: \_\_\_\_\_
- 16. Marital Status \_\_\_\_\_
- 17. Mother's Name: \_\_\_\_\_  
Last First MI
- 18. Social Security No. \_\_\_\_\_
- 19. Address: \_\_\_\_\_
- 20. Phone No. \_\_\_\_\_
- 21. Date of Birth: \_\_\_\_\_
- 22. Date of Death: \_\_\_\_\_
- 23. Marital Status \_\_\_\_\_

**CURRENT PARENTAL RELATIONSHIPS: (The persons, if other than biological parents, who will be working in a parental capacity with child while in care):**



46. Name any medications this child is not taking, and for what condition(s) \_\_\_\_\_

47. Name of child's physician: \_\_\_\_\_ 48. Phone No. \_\_\_\_\_

49. Address: \_\_\_\_\_

50. Name of child's dentist: \_\_\_\_\_ 51. Phone No. \_\_\_\_\_

52. Address: \_\_\_\_\_

#### IV. EDUCATIONAL INFORMATION

(If this form is completed between school terms, please give the information pertaining to the previous school year. If assistance is needed in completing the form, please consult the child's school).

53. Assigned School Grade ( ). In which grade(s) has the child been retained?( )

54. Attach copy of the child's report card for the latest reporting period.

55. School performance this year is: ( ) Better than; ( ) Equal to; ( ) Poorer than previous year.

56. Education setting: Regular Class ( ); Special Education ( ); Other (Specify): \_\_\_\_\_

57. Has child been classified as "special needs" under PL 94-142? ( ) If "yes" circle classification(s):  
AU BEH C/B HI EMH TMH SPMH MU OI OHI SLD SLI VI

58. Child's appointed Surrogate Parent: Name \_\_\_\_\_

59. Phone No. \_\_\_\_\_ 60. Address: \_\_\_\_\_

61. Name of Current/last school attended: \_\_\_\_\_

62. Phone No. \_\_\_\_\_ 63. Address: \_\_\_\_\_

64. School Transcript: Attached: ( ): Promised by date: \_\_\_\_\_

65. Latest Standardized Test:

Name of Test	Date of Test	Test Score
Achievement (CAT, etc.) _____	_____	_____
Mental Ability (WISC-R, etc) _____	_____	_____

66. Attendance record for school year:

Number of days in attendance: \_\_\_\_\_

Number of excused absences: \_\_\_\_\_

Number of unexcused absences (suspension, expulsion, truancy, etc.) \_\_\_\_\_

Explain: \_\_\_\_\_

67. Academic Strengths: \_\_\_\_\_

68. Academic weaknesses: \_\_\_\_\_

69. School behavioral strengths: \_\_\_\_\_

70. School behavioral weaknesses: \_\_\_\_\_

71. Attitude toward school (not included in above answers): \_\_\_\_\_

72. Recommended educational plan/program (IEP), etc: \_\_\_\_\_

73. Other special needs/talents, including extra-curricular activities and interests: \_\_\_\_\_

74. Additional school information pertinent to this application: \_\_\_\_\_

### V. SOCIAL HISTORY

**The following information will help agency staff understand the child's and family's needs and how best to meet these needs. If a written social history is available, it may be substituted for Section V (questions no 75-85). Answer any of the questions below which are not addressed in the social history).**

75. Tell what is going on in the family at this time. Describe the significant events which effect this family and child: \_\_\_\_\_

76. Give a brief description of this family's

a. Strengths: \_\_\_\_\_

b. Weaknesses: \_\_\_\_\_  
\_\_\_\_\_

77. Give a brief description of the child's

a. Strengths: \_\_\_\_\_  
\_\_\_\_\_

b. Weaknesses: \_\_\_\_\_  
\_\_\_\_\_

78. What and/or who makes this child

- a. Glad? \_\_\_\_\_
- b. Sad? \_\_\_\_\_
- c. Mad? \_\_\_\_\_
- d. Fight? \_\_\_\_\_
- e. Run? \_\_\_\_\_

79. From what agencies/professionals has the family sought or been given help? Specify services and results: \_\_\_\_\_  
\_\_\_\_\_

80. What religious resources/support systems are available to this child and family?  
(Name/phone of contact person) \_\_\_\_\_  
\_\_\_\_\_

81. Why must this child now live away from his/her parents? Attach description of previous out-of-home placement(s): \_\_\_\_\_  
\_\_\_\_\_

82. Why must this child now live away from his/her parents? Attach description of previous out-of-home placement(s): \_\_\_\_\_  
\_\_\_\_\_

**VI. PLANNING**

**(This section requires equal attention to the family and the child in answering the questions.)**

Page 6 of 7 (Child's Name)

86. What is the permanent plan for this child? \_\_\_\_\_

87. Is there a current need to revise the permanent plan? ( ) If "yes", explain \_\_\_\_\_

88. State the goals toward which the family and child are working in order to achieve the permanent plan: \_\_\_\_\_

89. What specific services of the agency are being requested on behalf of this family and child: \_\_\_\_\_

90. How will the requested services help the family and child achieve their permanent plan? \_\_\_\_\_

91. Identify in the order of your priority all agencies to which this application is being made:

(1) \_\_\_\_\_ (3) \_\_\_\_\_

(2) \_\_\_\_\_ (4) \_\_\_\_\_

92. Give the name/role of other volunteers/professionals assigned to this child (Guardian ad Litem, Child Advocate, Court Counselor, etc.) \_\_\_\_\_

**VII. ATTACHMENTS**

93. For each agency being considered, refer to the respective page of the CFSA-NC Directory of Member Agencies to determine what additional documentation is required as supporting information to the application. The documents listed below are attached to this application as supporting information to assist in the planning for the named child and family:

- |          |          |
|----------|----------|
| a. _____ | e. _____ |
| b. _____ | f. _____ |
| c. _____ | g. _____ |
| d. _____ | h. _____ |

**VIII. SIGNATURE (S)**

I (we), the undersigned, hereby apply to the (Name of agency) for services named above on behalf of the named child for whom I (we) hold legal custody and/or placement authority. I (we) certify that the information contained in this application and the attachments is true and accurate to the best of my (our) knowledge. I (we) agree to share additional information pertinent to this application and requested by the agency. I (we) also agree to cooperate with the agency and to support the plan of service to which we mutually agree.

XSignature of Parent(s) or Legal Custodian: \_\_\_\_\_ Date    /    /   

\_\_\_\_\_ Date    /    /   

Signature of Representative of Agency  
Holding Voluntary Placement Agreement: \_\_\_\_\_ Date    /    /

Client's Name & Record Number \_\_\_\_\_

## Adolescent Alternatives Admission Assessment and Screening

Client Record# \_\_\_\_\_  
Full Name \_\_\_\_\_ Date \_\_\_\_\_  
Date Of Birth \_\_\_\_\_  
Interviewee \_\_\_\_\_  
Therapist \_\_\_\_\_  
Race/Ethnic Group \_\_\_\_\_

### Current Assessment

Presenting Problems (Past & Present Behavior Problems at home, school, and within community) \_\_\_\_\_  
\_\_\_\_\_

Factors that contribute to presenting problems (culture, spiritual and ethnic factors, financial issues, background issues, family support, etc) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legal Status (law enforcement contact; probation; court charges; destruction of property, stealing, truancy, running away from home, etc) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Environment (family issues of concern; strengths and resources) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Individual Strengths \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client's Name & Record Number \_\_\_\_\_

Community Supports

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Initial Client Goal (Client's counseling goals, hobbies, interests, parent and or legal guardian expectation of treatment)

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### **Family/ Social History**

Family Dynamics (Parents, Grandparents, and siblings)

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Critical Family Events (Death, Divorce, Accidents, Pregnancy, Trauma and Losses)

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Family Medical Problems (Substance Abuse, Psychiatric Conditions)

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Social Relationships (Family Relationships, Peer Relationships, Church, etc)

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Physical, Emotional or Sexual Abuse History/Neglect/Family Violence

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Client's Name & Record Number \_\_\_\_\_

## School History

School Performance (Retained, Average Grades, Current and Past Testing)

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Behavioral Problems Suspension/Expulsions

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Special Classification (BEH, LD, BED, ADHD, EMH, AG)

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## History of Treatment

Name, Date, and Location of Previous Services

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Hospitalizations (Psychiatric/Medical)  
Reasons (When, Where, Diagnosis)

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Medical History

Medical Problems \_\_\_\_\_

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Physician \_\_\_\_\_

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Client's Name & Record Number \_\_\_\_\_

Medications \_\_\_\_\_  
\_\_\_\_\_

Critical Medical History (Allergies, disabilities, surgeries, diseases etc).  
\_\_\_\_\_

Sleep:  No change  Increased  Decreased  Restless  Nightmares  Other \_\_\_\_\_  
Appetite:  No change  Decreased  Increased  Weight ( loss  gain) Other \_\_\_\_\_  
Anxiety:  None  Increased Heart Rate  SOB  Palpitation  
 Hyperventilation  Chest Pain  Other \_\_\_\_\_

**Developmental History And Assessment**

Prenatal History (Drug/Alcohol Abuse (Illegal Substances))  
\_\_\_\_\_

Complications  
\_\_\_\_\_

Postnatal History  
\_\_\_\_\_

Developmental Milestone Type/Level Developmental Disability/  
\_\_\_\_\_  
\_\_\_\_\_

**Risk Assessment**

Suicidal Risk?  yes  no  
Risk Level Current Suicidal Ideation \_\_\_\_\_  
Current Suicidal Intent \_\_\_\_\_  
Access to means \_\_\_\_\_ Specify \_\_\_\_\_  
Previous Attempts/Gestures \_\_\_\_\_  
Specific Method and Medical Tx in past Attempts \_\_\_\_\_  
Family History of Suicide \_\_\_\_\_  
Current Deterrents to Suicide \_\_\_\_\_

Homicidal History (Dangers to others)  yes  no  
Violent History  Threats \_\_\_\_\_  
Current Threat  yes  no Mean & Access to victim: Specify \_\_\_\_\_

Mental Status Check  
Disorientation:  person  place  time  situation  
Affect:  Congruent  Flat  Inappropriate Affect  Blunted  Labile  
 Full Range

Comments \_\_\_\_\_

Client's Name & Record Number \_\_\_\_\_

Mood :  pleasant  sad  tearful  depressed  anxious  irritable  apathetic  
 Fearful  hostile  angry  helpless  hopeless  Tense  euphoric

Comments \_\_\_\_\_

Thought Content:  Normal  Auditory Hallucination  Visual Hallucinations  
 Tactile Hallucinations  Tangential  Bizarre  Paranoid  Flashbacks  
 Preoccupations

Estimated Intellectual Functioning Level:  Below Average  Average  Above Average  Superior

Comments \_\_\_\_\_

Memory: Recent:  Intact  Impaired  
Remote:  Intact  Impaired

Attention/Concentration:  Confused  Inattentive  Distractible  Variable

Comments \_\_\_\_\_

Impulse Control:  Mild  Moderate  Severe

Comment: \_\_\_\_\_

Appearance: Hygiene  Good  Poor

Dress:  Neat  Casual  Dirty  Bizarre

Comments: \_\_\_\_\_

Visual :  Normal  Need Assistance Specify \_\_\_\_\_

Speech/Hearing Impaired:  yes  no

Comments \_\_\_\_\_

Vocational History \_\_\_\_\_

Diagnostic Impressions: DSM IV

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Axis V GAF  CAFAS \_\_\_\_\_

Initial Treatment Goals \_\_\_\_\_

\_\_\_\_\_