**SOCIAL INTAKE FORM**

**Purpose: To determine the psycho-social needs of students and make appropriate referrals and case management plans.**

|  |
| --- |
| **DEMOGRAPHIC INFORMATION** |
| **Student Name:** |  | **Student ID:** |  |
| **E-mail:** |  | **Status:** | [ ]  **Resident** [ ]  **Non-Resident** |
| **Address:** *(Include City, State, Zip Code)* |  |
| **DOE:** |  | **DOB:** |  | **Age:** |  | **Cell Phone #:**  | **(****)**  |
| **FAMILY BACKGROUND** |
| **Mother/Guardian** | **Father/Guardian** |
| **Name:**  | **Name:** |
| **Address:** | **Address:** |
| **City:** | **City:** |
| **State:** | **State:** |
| **Zip Code:** | **Zip Code:** |
| **Phone #: (     )** | **Phone #: (     )** |
| **Do you have any siblings?** | [ ]  Yes [ ]  No | **If yes, how many:** |
| **Do you have any children?** | [ ]  Yes [ ]  No | **If yes, how many:** |
| **Provide children’s name(s) and age(s):**Name:  Age:  Name:  Age:  Name: Age:  Name:  Age:   |
| **Has the Job Corps child allotment been explained to you?**  | [ ]  Yes [ ]  No | **Who is the day care provider for your child(ren)?** |
| **Who raised you?** |  | **Whom have you lived with for the past year?** |  |
| **How long have you lived there?** |  | **Do you like living there?** |  [ ]  Yes [ ]  No |
| **If a minor, do you live with your parent?** | [ ]  Yes [ ]  No | **If no, the reason is:** |
| **Do you have a caseworker?** | [ ]  Yes [ ]  No | **If yes, caseworker’s name:****Phone #: (     )**  |
| **Military/Discharge Type:** |  |
| **Describe your relationship with the following people (e.g., excellent, good, fair, poor, none):****Mother/guardian:** **Father/guardian:** **Siblings:** **Significant other/spouse:** **Friends:** **Others (e.g., teachers, bosses, etc.):**  |
| **LEGAL ISSUES** |
| **Have you ever been in trouble with the police?** | [ ]  Yes [ ]  No | If yes, for what and when (year): |
| **Are you presently awaiting charges, court, or sentencing?** | [ ]  Yes [ ]  No | If yes, for what: |
| **Are you currently on probation?**  | [ ]  Yes [ ]  No | If yes, provide probation officer’s informationName: Phone#: **(     )**Address:City, State, Zip Code: |
| **EDUCATION BACKGROUND** |
| **Did you receive any special education or resource classes?** | [ ]  Yes [ ]  No | If yes, in what areas and when (years)? |
| **If you did not complete school why did you stop and when (year)?** |  |
| **Were you ever suspended or expelled?** | [ ]  Yes [ ]  No | If yes, how many times and reason(s): |
| **WELLNESS SUPPORT** |
| Job Corps wants to support you with your career goals. Often, personal issues can interfere with your career goals. Job Corps offers a full program of support. Information will be confidential and shared only with staff/agencies with a need to know as required by Job Corps or state laws. |
| **Have you ever been to see a psychologist, therapist, psychiatrist, counselor, or social worker, or been in any kind of counseling before?**  | [ ]  Yes [ ]  No | If yes, for what reason and when (years):How many times?Approximate date of last appointment: |
| **Have you ever received or taken any medicine to help you with feeling sad, worrying, having trouble paying attention, or for behavior?** | [ ]  Yes [ ]  No | If yes, when (year)?What was the medicine?Who gave it to you?How long did you take it? |
| **EMOTIONAL WELLNESS—Part 1** |
| Are you **NOW** (e.g., last few days or weeks) having any of the following: *(Check all that apply)* |
| **Depression** | [ ]  Having sleep or appetite problems [ ]  Having low energy [ ]  Wanting to be alone more than usual[ ]  Crying often [ ]  Feeling sad or hopeless [ ]  None reported |
| **Poor Self-esteem** | [ ]  Feeling worthless [ ]  Feeling you can’t do anything right [ ]  Putting yourself down [ ]  None reported |
| **Suicidal Thoughts/Ideas** | [ ]  Thoughts of hurting or killing yourself [ ]  Have a plan to hurt or kill yourself[ ]  Have access to a way to hurt or kill yourself [ ]  None reported |
| **Homicidal Thoughts/ Ideas** | [ ]  Thoughts of hurting or killing someone [ ]  Have a plan to hurt or kill someone [ ]  None reported |
| **Anger issues** | [ ]  Getting easily irritated [ ]  Punching the wall or things [ ]  Punching people or animals[ ]  Having a bad temper or trouble controlling violent behavior [ ]  None reportedHow would you respond to someone disrespecting you?        |
| **Grief (Feeling sad about or dealing with loss)** | [ ]  Family member [ ]  Friend [ ]  Someone else you were close to or knew [ ]  None reported |
| **Anxiety** | [ ]  Feeling stressed out or fearful [ ]  Having panic attacks [ ]  Often feeling very worried [ ]  None reported |
| **Auditory or Visual Hallucinations** | [ ]  Hearing voices when no one else is around [ ]  Seeing things that other people around you do not see [ ]  None reported |
| **Self-Injury Behaviors** | [ ]  Cutting [ ]  Burning [ ]  Other ways *(specify)*       [ ]  None reported |
| **Sleep Problems** | [ ]  Nightmares [ ]  Having trouble falling or staying asleep [ ]  Bed wetting [ ]  None reported |
| **Attention or Concentration Issues** | [ ]  ADD [ ]  ADHD (Attention-Deficit/Hyperactivity Disorder) [ ]  Having too much energy [ ]  Acting without thinking [ ]  Can’t sit still [ ]  Can’t complete tasks [ ]  Get bored very fast [ ]  None reported |
| **Eating Issues** | [ ]  Starving yourself [ ]  Eating in secret [ ]  Over eating [ ]  Making yourself throw up[ ]  Bingeing [ ]  Eating till you feel sick [ ]  Using laxatives to control weight [ ]  Exercising out of control (>3 hours or exercising to the point that you miss work/school) [ ]  None reported |
| **Sexual/Sexuality Issues** | [ ]  Feeling bad about sexual behavior, thoughts or feelings[ ]  Feeling confused or concerned about sexual orientation/gender [ ]  None reported |
| **Relationship Issues** | With: [ ]  Family [ ]  Partner [ ]  Friends [ ]  Gang members [ ]  None reported |
| **Parenting Issues** | [ ]  Fighting with your child’s other parent [ ]  Feeling overwhelmed by child-rearing responsibilities  [ ]  None reported |
| **EMOTIONAL WELLNESS—Part 2** |
| Have you **EVER** experienced any of the following: |
| **Bullying or been accused of bullying?** | [ ]  Yes [ ]  No If yes, please explain:   |
| **Abuse, Verbal Abuse, Sexual Abuse or Physical Abuse?** | [ ]  Yes [ ]  No If yes, did the abuse stop? [ ]  Yes [ ]  NoWould you like to talk with someone about the abuse? [ ]  Yes [ ]  No |
| **A traumatic event such as an accident, natural disaster (e.g. hurricane, flood, fires) or an act of violence that you:**  | [ ]  Had nightmares about it or thought about it when you did not want to[ ]  Tried hard not to think about it or went out of your way to avoid situations that  reminded you of it[ ]  Were constantly on guard, watchful, or easily startled [ ]  None reported |
| **Thoughts of hurting or killing yourself?**  | [ ]  Yes [ ]  No If yes, when (month and year)?       Did you try to hurt or kill yourself? [ ]  Yes [ ]  NoWhat problems made you feel suicidal?       Do you feel these problems have gone away? [ ]  Yes [ ]  No |
| **Have you ever gone to the emergency room or been admitted to the hospital for any of the above problems?** | [ ]  Yes [ ]  No If yes, when (years)?  What hospital?  How long did you stay there?  Was it helpful? [ ]  Yes [ ]  No |
| **ALCOHOL AND DRUGS:** |
| During the past 12 months have you: |
| **1. Drank any alcohol (more than a few sips)?** |  [ ]  Yes [ ]  No |
| **2. Smoked any marijuana?**  |  [ ]  Yes [ ]  No |
| **3. Used anything else to get "high"?**  |  [ ]  Yes [ ]  No |
| *If you answered NO to all three questions above, answer Question 4 only.**If you answered YES to any of the questions above, answer Questions 4 through 9*[[1]](#footnote-1) |
| **4. Have you ever ridden in a CAR driven by someone (including yourself) who was** **"high" or had been using alcohol or drugs?** |  [ ]  Yes [ ]  No |
| **5. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?** |  [ ]  Yes [ ]  No |
| **6. Do you ever use alcohol/drugs while you are by yourself, ALONE?** |  [ ]  Yes [ ]  No |
| **7. Do you ever FORGET things you did while using alcohol or drugs?** |  [ ]  Yes [ ]  No |
| **8. Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?**  |  [ ]  Yes [ ]  No |
| **9. Have you gotten into TROUBLE while you were using alcohol or drugs?** |  [ ]  Yes [ ]  No |

|  |
| --- |
| *Everyone answers Questions 10 and 11* [[2]](#footnote-2) |
| **10. Are you bothered by a close friend/family member/partner’s alcohol or drug use?** |  [ ]  Yes [ ]  No |
| **11. In the past three months have you used any type of tobacco product?** |  [ ]  Yes [ ]  No |
| **PROTECTIVE FACTORS** |
| **When you are upset, what helps you relax?** |  |
| **What is your favorite thing to do in your free time?** |  |
| **Do you have any religious/faith based/cultural practices you participate in?** | [ ]  Yes [ ]  No If yes, which religion/faith based/cultural practice?        |
| **What do you consider your strengths/talents?** |  |
| **Do you want assistance in dealing with any of the behaviors checked on this form?** | [ ]  Yes (Complete next readiness section)[ ]  No (I understand that I may seek help at any time – Skip next  readiness section) |
| **READINESS FOR CHANGE** |
| If you want help, how ready are you to consider changing any of the behaviors checked on this form? **0 1 2 3 4 5 6 7 8 9 10** [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Not Ready Thinking About It Ready |
| **How can we be helpful to you at this time in making a change right now?**  |  |

Student Signature Date

Counselor Signature Date

**Reviewed by:**

Counseling Manager Date

Center Mental Health Consultant Date

TEAP Specialist Date

**Items for Intervention Plan: (*to be completed by Counselor)***

[ ]  TEAP REFERRAL [ ]  SPECIAL GROUPS [ ]  TUPP REFERRAL [ ]  ACADEMIC REFERRAL

[ ]  MENTAL HEALTH REFERRAL [ ]  RECREATION REFERRAL [ ]  HEALS REFERRAL [ ]  PHYSICIAN REFERRAL

Identify Special Group(s), if checked above:

Comments regarding student’s motivation and needs, if applicable:

1. Questions 4 through 9 are from the CRAFFT-Massachusetts Department of Public Health Bureau of Substance Abuse Services. Boston, MA. Massachusetts Department of Public Health, 2009. [↑](#footnote-ref-1)
2. Questions 10 and 11 are not part of the CRAFFT and are not scored as part of this screening tool. [↑](#footnote-ref-2)