**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 information  Name: 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 reported  How 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  No  Would 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  No  What 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)