

INTAKE INFORMATION
Adults

Date _____

Client Name _____

Address _____ Home Phone: _____

City _____ Zip _____ Work Phone: _____

Birthdate _____ Present Age _____ Occupation _____

Education _____ Employer _____

Referral Source _____

May we have your permission to let referral know you came to BCA? () Yes () No

Immediate Family Residing IN the Home (Please circle the appropriate reference)

Husband/Wife/Significant Other _____

Marital History _____

Occupation _____ Education _____

Home Phone _____ Work Phone _____

Children/Step-Children/Siblings

| Name | Relationship | Age | Birthday | Education/Occupation |
|------|--------------|-----|----------|----------------------|
| | | | | |
| | | | | |
| | | | | |

Immediate Family Residing Outside the Home Children/Step-Children/Siblings

| Name | Relationship | Age | Birthday | Education/Occupation |
|------|--------------|-----|----------|----------------------|
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| | | | | |
| | | | | |

Please circle services you are seeking: Individual Counseling Play Therapy Family Counseling EAP Services
Psychological Testing Vocational Testing Intellectual/Educational Testing

Current Problem – Describe in one or two sentences the problem for which you want to help.

In order for you to have more useful time with your counselor, please answer all of the questions as accurately as possible.

Health Information:

Name of your doctor _____

Address/Phone: _____

Any current medical problems? _____

What medication are you taking? _____

Are your current medical problems being treated? _____

Have you seen a counselor, psychologist or psychiatrist before? _____ If yes, who and when: _____

For what reasons? _____

Have you ever been hospitalized for an emotional or drug/alcohol problem? _____ If yes, where and when: _____
 For what reasons? _____

| | |
|---|--|
| <p>Please rate these symptoms using the following scale:</p> <p>0 = Never 1 = Little of the time 2 = Some of the time 3 = Good part of the time 4 = Most or all of the time</p> <p>Please record your rating in the space at the left of each item.</p> | <p>_____ Nervous and anxious _____ Upset easily or feel panicky _____ Headache, neck and backache _____ Digestive problems _____ Dizzy spells _____ Crying spells or feel like it _____ Sleep disturbance _____ Losing or gaining weight (not on diet) _____ Restless and can't keep still _____ Feel other would be better off if he/she were dead</p> |
|---|--|

Please check the following items as they pertain to you

| Chemical Use History | YES | NO |
|--|-------|-------|
| Do you use drugs? | _____ | _____ |
| Do you use alcohol? | _____ | _____ |
| Do you sometime drink more than you had planned? | _____ | _____ |
| Have family/friends ever expressed concern about your use of alcohol? | _____ | _____ |
| Have you ever been arrested for alcohol related charges? | _____ | _____ |
| Have you ever had episodes where you were unable to remember periods when you were drinking? | _____ | _____ |
| Have family/friends ever expressed concern over your use of drugs? | _____ | _____ |
| Have you ever been arrested for any offense involving drugs? | _____ | _____ |
| Have you ever been treated for drug abuse? | _____ | _____ |
| Have you ever overdosed on drugs accidentally? | _____ | _____ |
| Have you ever purposely overdosed on drugs? | _____ | _____ |
| Has any member of your family had problems with drugs or alcohol? | _____ | _____ |
| Do you use nicotine? | _____ | _____ |

| Risk Factors | YES | NO |
|--|-------|-------|
| Do you know anyone who has ever attempted suicide? | _____ | _____ |
| Have you, in the last year, ever considered suicide? | _____ | _____ |
| Have you ever attempted suicide? | _____ | _____ |
| Have your personal problems affected your job performance in any way? If yes, how? | _____ | _____ |
| Have you ever been exposed to serious trauma? If yes, how? | _____ | _____ |
| Have you ever been sexually abused? | _____ | _____ |
| Have you ever been asked or forced to engage in touching, sexual activity against your will? | _____ | _____ |

| Legal History | YES | NO |
|--|-------|-------|
| Presently, are you involved in any legal problems? | _____ | _____ |
| Have you had legal problems in the past? | _____ | _____ |
| If yes to either question, please explain: | _____ | |

Who should we contact in case of an emergency? _____
 Name _____ Phone Number _____