

**INTAKE INFORMATION**  
**Children & Adolescents**

Date \_\_\_\_\_

Client Name \_\_\_\_\_

Address \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Parents' Marital Status**  
( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Birthdate \_\_\_\_\_ Present Age \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

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)

**Father** \_\_\_\_\_

**Mother** \_\_\_\_\_

Step-Mother \_\_\_\_\_

Step-Father \_\_\_\_\_

Marital History \_\_\_\_\_

Marital History \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Education \_\_\_\_\_

Education \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Siblings and all other individuals residing in the home

Name	Relationship	Age	Birthday	Education/Occupation

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

Name	Relationship	Age	Birthday	Education/Occupation

**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.

**\*\*\*Complete reverse side**

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 child's doctor \_\_\_\_\_ Address/Phone: \_\_\_\_\_

Any current medical problems? \_\_\_\_\_

What medication is your child taking? \_\_\_\_\_

Are your child's current medical problems being treated? \_\_\_\_\_

Has your child seen a counselor, psychologist or psychiatrist before? \_\_\_\_\_ If yes, who and when: \_\_\_\_\_

For what reasons? \_\_\_\_\_

<p>Please rate the symptoms you have observed in Your child 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          _____ Defiant/disobedient          _____ Headache, neck and backache and/or digestive problems          _____ Low self-esteem          _____ Easily distracted/inattentive          _____ Crying spells or feel like it          _____ Bad dreams          _____ Trouble getting to sleep/staying asleep          _____ 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>
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Please check the following items as they pertain to your child

<b>Chemical Use History</b>	YES	NO
Does your child use drugs?	_____	_____
Does your child use alcohol?	_____	_____
Have family or friends ever expressed concern about your child's use of alcohol?	_____	_____
Has your child ever been arrested for alcohol related charges?	_____	_____
Has your child ever overdosed on drugs purposely or accidentally?	_____	_____
Has any member of your family had problems with drugs or alcohol?	_____	_____
Does your child use tobacco?	_____	_____

<b>Legal History</b>	YES	NO
Presently, is your child involved in any legal problems?	_____	_____
Have you or your child had legal problems in the past?	_____	_____
If yes, please explain:		

<b>Risk Factors</b>	YES	NO
Does your child know anyone who has ever attempted suicide?	_____	_____
Have you or your child ever threatened suicide?	_____	_____
Has your child's personal problems affected school performance in any way?	_____	_____
If yes, how?		
Has your child ever been exposed to serious trauma?	_____	_____
Has your child ever been physically abused?	_____	_____
Has your child ever been sexually abused?	_____	_____

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