INTAKE INFORMATION

CHILDREN AND ADOLESCENTS

Date_____

Child's Name _____

Address _____

Home/Cell _____ Email _____

Date of Birth _____ Age _____

Name of School Attending _____ Grade _____

Parents' Marital Status:_____ Married _____ Divorced _____Separated _____Widowed

If divorced or separated, has the other parent been notified that the child is being seen for services at BCA? How does the other parent feel about this? (If the other parent has not been notified, please explain why)

_____

_____

Father _____ Mother _____

Date of Birth _____ Date of Birth _____

Step-Mother _____ Step-Father _____

Marital History _____ Marital History _____

Occupation _____ Occupation _____

Cell _____ Cell _____

Email _____ Email _____

Immediate Family (children/step-children/parent/siblings)

Name	Relationship	Birthday	Education/Occupation	in home?
				☐
				☐
				☐

Services you are seeking: ☐ Individual Therapy ☐ Play Therapy ☐ Family Therapy

Reason for seeking counseling:

_____

_____

_____

[PLEASE COMPLETE BACK PAGE]

Health Information:

Child's Doctor _____ Phone _____

Address _____

Current medical problems _____

Are they being treated? ☐ Yes ☐ No

Current medications taken _____

Has your child seen a counselor, psychologist or psychiatrist before? ☐ Yes ☐ No

If yes, who, when and why? _____

_____

Please rate these symptoms you have observed in your child using the following scale:

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

Please record your rating in the space at the left of each item.

Digestive problems _____

Nervous and anxious _____

Defiant/disobedient _____

Headache, neck and backache (circle all that apply) _____

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 others would be better off if he/she were dead _____

Please check the following items as they pertain to your child:

Chemical Use History

	Yes	No
Does your child use drugs?	☐	☐
Does your child use alcohol?	☐	☐
Have family/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?	☐	☐

Legal Issues

Presently, is your child involved in any legal problems?	☐	☐
Have you or your child had legal problems in the past?	☐	☐

If yes, explain _____

_____

Risk Factors

	Yes	No
Does your child know anyone who has ever attempted suicide?	☐	☐
Have you or your child ever threatened suicide?	☐	☐
Have your child's personal problems affected school performance in any way?	☐	☐

If yes, how? _____

_____

Has your child ever been exposed to serious trauma?	☐	☐

If yes, how? _____

_____

Has your child ever been physically abused?	☐	☐
Has your child ever been sexually abused?	☐	☐

Referral Source _____ May we contact? ☐ YES ☐ NO

ER Contact _____ Phone Number _____