INTAKE INFORMATION
CHILDREN AND ADOLESCENTS

Date _____

Child's Name _____

Address _____

City State Zip

Home/Cell _____ Email _____

Date of Birth _____ Present Age _____ Grade _____

Parent's Marital Status: _____ Married _____ Divorced _____ Separated _____ Widowed

Referral Source _____

May we have your permission to let referral know you came to BCA? _____

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

Father _____ Mother _____

Step-Mother _____ Step-Father _____

Marital History _____ Marital History _____

Occupation _____ Occupation _____

Home _____ Home _____

Cell _____ Cell _____

Email _____ Email _____

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 the services you are seeking: Individual Counseling Play Therapy Family Counseling

Reason for seeking counseling:

_____

_____

_____

(PLEASE COMPLETE BACK PAGE)

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

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 _____

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?	___	___
Has 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?	___	___

Who should we contact in case of emergency _____

(Name/Relationship) (Number)