Building Foundations Counseling Center, Inc.
A Professional Family Counseling Corporation

Child/Adolescent Intake Form

PATIENT INFORMATION

Patient Name:	Patient's Date of Birth:	Current Age:	Gender:	Today's Date:

Patient's Social Security Number:	Ethnicity	If Adolescent – Cell Phone:

PARENT/LEGAL GUARDIAN INFORMATION – Minor Lives with: ☐ Dad ☐ Mom ☐ Both ☐ Guardian

Parent/Guardian's Name:	Date of Birth:	Home Phone:	Cell Phone:

Parent/Guardian's Address:	Parent/Guardian's Email:

Parent/Guardian's Name:	Date of Birth:	Home Phone:	Cell Phone:

Parent/Guardian's Address:	Parent/Guardian's Email:

Additional Guardian's Name:	Date of Birth:	Home Phone:	Cell Phone:

Additional Guardian's Address:	Additional Guardian's Email:

REFERRAL INFORMATION

Reason for Referral: ☐ Individual ☐ Couples ☐ Family ☐ Group Therapy ☐ Other: _____

Referred By:	Phone:	Address:

INSURANCE INFORMATION

How do you intend to pay for services? ☐ Private Pay ☐ Insurance ☐ Victim Witness ☐ EAP ☐ Other:_____

Insurance Name:	Insurance Phone Numbers:

Insurance Address:	Subscriber's Name:

Subscriber's Social Security Number:	Subscriber's Date of Birth:	Relationship to Patient:

Member ID#:	Group ID#:

Name and Address of Subscriber's Employer:	Employer's Phone Number:	Is there secondary Insurance? ☐ YES ☐ NO (If YES, list on back)

Victim Witness Claim #	Victim Witness Date of Incident:	EAP Authorization #:	EAP # Sessions

EMERGENCY CONTACT

Name:	Phone:	Relationship to You:

MEDICAL INFORMATION

Primary Pediatrician Name:	Phone:
Medications Currently Taking:	
Medical Conditions (Please include allergies, asthma, diabetes, etc):	
Describe Minor's Developmental History: (Include Pregnancy/Delivery, Infancy Milestones Met/Delayed, Age Started School, etc)	
May we have your permission to contact pediatrician to coordinate Minor's treatment? ☐ YES ☐ NO	

SUBSTANCE ABUSE INFORMATION

Has Minor ever been in a 12-Step program? ☐ YES ☐ NO If YES, please explain:

Please check if Minor has ever used or experimented with any of the following:

☐ Tobacco	☐ Alcohol	☐ Caffeine	☐ Ecstasy
☐ Marijuana	☐ PCP	☐ Mushrooms	☐ Methamphetamines
☐ Inhalants (Spray Paint/Aerosols)	☐ Prescription Medications	☐ Others: _____	

Any history of substance abuse/addiction with any other family members? ☐ YES ☐ NO	If YES, please explain:

MENTAL HEALTH TREATMENT

	YES	NO	Name of Clinic or Person	List of Diagnoses, Medication, Type of Counseling or Service	Comments
Counseling Services:					
Psychiatric Treatment:					
Drug/Alcohol Treatment:					
Hospitalizations:					

Is Minor currently having any suicidal thoughts? ☐ YES ☐ NO	If YES, please explain:
Has Minor ever attempted to harm themselves currently or in the past? ☐ YES ☐ NO	If YES, please explain:
Is Minor currently having any homicidal thoughts? ☐ YES ☐ NO	If YES, please explain:

May we contact Minor's current/recent treating psychiatrist listed above to coordinate your treatment? ☐ YES ☐ NO ☐ N/A

May we contact Minor's previous treating therapist or counselor above for continuity of care? ☐ YES ☐ NO ☐ N/A

FAMILY MEMBERS/SIGNIFICANT OTHERS LIVING IN HOME OR IN MINOR's LIFE

Name:	Age:	Relationship:
Name:	Age:	Relationship
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

Describe relationship Minor has with Dad:

Describe relationship Minor has with Mom:

Describe relationship Minor has with Guardian (If applicable):

Describe relationship Minor has with Siblings:

SCHOOL INFORMATION

Name of School or Daycare:	Phone:
School Contact/Teacher:	Current Grade Attending:

List any Special Education Services:	Current IEP? ☐ YES ☐ NO	Participating in G.A.T.E. Programs? ☐ YES ☐ NO

Please check any of the following with regards to Minor's approach to school:

☐ Organized	☐ Over-Achiever	☐ Disorganized	☐ Does Minimum Required
☐ Responsible	☐ Perfectionistic	☐ Sloppy/Messy	☐ Does Only What's Expected
☐ Interested/Motivated	☐ Easily Over-Whelmed	☐ Doesn't Complete Assignments	☐ Refuses
☐ Self-Directed	☐ Can't Prioritize	☐ No Initiative	☐ Argumentative
☐ Cooperative		☐ Bored/Unaware	
☐ Not Excessively Anxious			

Please check any of the following with regards to Minor's feelings about school:

☐ Eager	☐ Bored	☐ Frustrated/Angry	☐ Fearful	☐ Doesn't Feel Good Enough
☐ Enthusiastic	☐ Apathetic	☐ Passive	☐ Depressed	☐ Confused
☐ Enjoys	☐ Avoidant	☐ Anxious	☐ Panics	☐ Other:_____

Please check any of the following with regards to Minor's peer relationships:

☐ Spontaneous	☐ Follower	☐ Passive	☐ Preferred Peers 2+ yrs. Older
☐ Makes Friends Easily	☐ Leader	☐ Difficulty Making Friends	☐ Preferred Peers 2+ yrs. Younger
☐ Shares Easily	☐ Manipulates Others	☐ Doesn't Get Invited to Play	☐ Socially Awkward/Immature
☐ Maintains Friendships	☐ Bossy	☐ Overly Sensitive	☐ Easily Annoyed
☐ Has Long Time Friends	☐ Assertive	☐ Takes Everything Personally	☐ Other: _____

CURRENT CONCERNS AND SYMPTOMS

Please describe the problems the Minor is seeking help for at this time:

How long have there been concerns about these problems?

Any observations regarding any times that these symptoms/behaviors increase or decrease?

Please check any of the following if they are "typical" for Minor:

☐ Affectionate	☐ Dizziness	☐ Learning Problems	☐ Refuses to Comply
☐ Aggressive	☐ Eating Disorder	☐ Lies Frequently	☐ Repetitive Behaviors
☐ Alcohol Problems	☐ Enthusiastic	☐ Listens to Reason	☐ Sad
☐ Angry	☐ Expects Failure	☐ Loner	☐ Screaming
☐ Anxiety	☐ Fatigue	☐ Low Self-Esteem	☐ Selfish
☐ Argues Frequently	☐ Fearful	☐ Manipulative	☐ Separation Anxiety
☐ Attention Seeking	☐ Feelings Easily Hurt	☐ Messy	☐ Sets Fires
☐ Avoid Adults	☐ Fidgety/Constant Motion	☐ Moody	☐ Sexually Acting Out
☐ Back Talk/Sass	☐ Frequent Injuries	☐ Nervous	☐ Short Attention Span
☐ Bedwetting	☐ Friendly	☐ Nightmares/Night Terrors	☐ Shy/Timid
☐ Blames Others	☐ Frustrated Easily	☐ Non-Compliant	☐ Sleeping Problems
☐ Blinking/Jerking	☐ Generous	☐ Obedient	☐ Social/Outgoing
☐ Bullies/Threatens	☐ Hallucinations	☐ Often Sick	☐ Soils Bed/Clothes
☐ Careless/Reckless	☐ Headaches Frequently	☐ Optimistic	☐ Speech Problems
☐ Clumsy	☐ Head Banging	☐ Oppositional	☐ Steals
☐ Confident	☐ Hoards	☐ Over Active	☐ Stomach Aches
☐ Cooperative	☐ Hopelessness	☐ Over Weight	☐ Swears
☐ Cries Easily	☐ Hyperactive	☐ Panic Attacks	☐ Tantrums
☐ Cyber Addiction	☐ Hurts Animals	☐ Perfectionistic	☐ Truant/School Avoiding
☐ Dawdles/Wastes Time	☐ Imaginary Friends	☐ Pessimistic	☐ Wets Cloths/DayTime
☐ Defiant	☐ Immature	☐ Picks at Skin/Scabs	☐ Whining
☐ Dependent	☐ Impulsive	☐ Poor Appetite	☐ Withdrawn
☐ Depression	☐ Independent	☐ Poor Concentration	☐ Worries Excessively
☐ Destructive	☐ Interrupts	☐ Pornography	☐ Other:
☐ Difficulty with Divorce	☐ Irritable	☐ Power Struggles	
☐ Disruptive	☐ Lacks respect for Adults	☐ Pulls Hair Out	
	☐ Lazy		

Please describe any of the above or other concerns:

How are problem behaviors generally handled?

What does the Minor do with unstructured time?

RELATIONSHIP CONCERNS

☐ Problems with other kids	☐ Problems with Siblings	☐ Problems with Parent Dating
☐ Problems with Parents	☐ Problems with Step-Parent	☐ Problems with Sibling Moving Out
☐ Problems with Parent's Divorce	☐ Problems with Step-Siblings	☐ Problems with Grades/Learning
☐ Problems with Teachers	☐ Problems with Grandparents	☐ Other: _____

Has the Minor experienced death of (friend, family member, pet, other)? ☐ YES ☐ NO If YES, please describe:

Has there been any other significant changes or events in Minor's life? (adoption, moving, fire, car accident, divorce, remarriage, victim/witness of a crime/abuse, etc.) ☐ YES ☐ NO If YES, please describe:

Are there any cultural values or spiritual beliefs that would help therapist to understand Minor better?

GOALS FOR THERAPY

What are the goals/wishes/expectations of Minor's therapy?

Is there any other information that would assist the therapist in understanding the Minor and/or the current concerns/problems?