

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

**Child/Adolescent Intake Form**

<b>PATIENT INFORMATION</b>				
Patient Name:	Patient's Date of Birth:	Current Age:	Gender:	Pronoun Preferred:
Patient's Social Security Number:	Ethnicity	If Adolescent – Cell Phone:	Today's Date:	
<b>PARENT/LEGAL GUARDIAN INFORMATION</b>				
Parent's Name:	Date of Birth:	Home Phone:	Cell Phone:	
Address: (Street, City and Zip):			Relationship to Patient:	
Does Parent Have Legal Custody? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does Patient Live With Parent? <input type="checkbox"/> YES <input type="checkbox"/> NO	Email:		
Parent's Name:	Date of Birth:	Home Phone:	Cell Phone:	
Address: (Street, City and Zip):			Relationship to Patient:	
Does Parent Have Legal Custody? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does Patient Live With Parent? <input type="checkbox"/> YES <input type="checkbox"/> NO	Email:		
<b>REFERRAL INFORMATION</b>				
Reason for Referral: <input type="checkbox"/> Individual <input type="checkbox"/> Couples <input type="checkbox"/> Family <input type="checkbox"/> Group Therapy <input type="checkbox"/> Other: _____				
Referred By:	Phone:	Address:		
<b>INSURANCE INFORMATION</b>				
How do you intend to pay for services? <input type="checkbox"/> Private Pay <input type="checkbox"/> Insurance <input type="checkbox"/> Victim Witness <input type="checkbox"/> EAP <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, list on back)	
Victim Witness Claim #	Victim Witness Date of Incident:	EAP Authorization #:	EAP # Sessions	
<b>EMERGENCY CONTACT</b>				
Name:	Phone:	Relationship to You:		

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

**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? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**SUBSTANCE ABUSE INFORMATION**

Has Minor ever been in a 12-Step program? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please explain:	
Please check if Minor has ever used or experimented with any of the following:	
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Marijuana	<input type="checkbox"/> PCP
<input type="checkbox"/> Inhalants (Spray Paint/Aerosols)	<input type="checkbox"/> Prescription Medications
<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Mushrooms
<input type="checkbox"/> Methamphetamines	<input type="checkbox"/> Others: _____
Any history of substance abuse/addiction with any other family members? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please explain:				
Has Minor ever attempted to harm themselves currently or in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please explain:				
Is Minor currently having any homicidal thoughts? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please explain:				
May we contact Minor's current/recent treating psychiatrist listed above to coordinate your treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A					
May we contact Minor's previous treating therapist or counselor above for continuity of care? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A					

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

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:		
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Participating in G.A.T.E. Programs? <input type="checkbox"/> YES <input type="checkbox"/> NO
Please check any of the following with regards to Minor's approach to school:		
<input type="checkbox"/> Organized <input type="checkbox"/> Responsible <input type="checkbox"/> Interested/Motivated <input type="checkbox"/> Self-Directed <input type="checkbox"/> Cooperative <input type="checkbox"/> Not Excessively Anxious	<input type="checkbox"/> Over-Achiever <input type="checkbox"/> Perfectionistic <input type="checkbox"/> Easily Over-Whelmed <input type="checkbox"/> Can't Prioritize	<input type="checkbox"/> Disorganized <input type="checkbox"/> Sloppy/Messy <input type="checkbox"/> Doesn't Complete Assignments <input type="checkbox"/> No Initiative <input type="checkbox"/> Bored/Unaware
<input type="checkbox"/> Does Minimum Required <input type="checkbox"/> Does Only What's Expected <input type="checkbox"/> Refuses <input type="checkbox"/> Argumentative		
Please check any of the following with regards to Minor's feelings about school:		
<input type="checkbox"/> Eager <input type="checkbox"/> Enthusiastic <input type="checkbox"/> Enjoys	<input type="checkbox"/> Bored <input type="checkbox"/> Apathetic <input type="checkbox"/> Avoidant	<input type="checkbox"/> Frustrated/Angry <input type="checkbox"/> Passive <input type="checkbox"/> Anxious
<input type="checkbox"/> Fearful <input type="checkbox"/> Depressed <input type="checkbox"/> Panics		
<input type="checkbox"/> Doesn't Feel Good Enough <input type="checkbox"/> Confused <input type="checkbox"/> Other: _____		
Please check any of the following with regards to Minor's peer relationships:		
<input type="checkbox"/> Spontaneous <input type="checkbox"/> Makes Friends Easily <input type="checkbox"/> Shares Easily <input type="checkbox"/> Maintains Friendships <input type="checkbox"/> Has Long Time Friends	<input type="checkbox"/> Follower <input type="checkbox"/> Leader <input type="checkbox"/> Manipulates Others <input type="checkbox"/> Bossy <input type="checkbox"/> Assertive	<input type="checkbox"/> Passive <input type="checkbox"/> Difficulty Making Friends <input type="checkbox"/> Doesn't Get Invited to Play <input type="checkbox"/> Overly Sensitive <input type="checkbox"/> Takes Everything Personally
<input type="checkbox"/> Preferred Peers 2+ yrs. Older <input type="checkbox"/> Preferred Peers 2+ yrs. Younger <input type="checkbox"/> Socially Awkward/Immature <input type="checkbox"/> Easily Annoyed <input type="checkbox"/> Other: _____		

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

**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:

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

Please describe any of the above or other concerns:

How are problem behaviors generally handled?

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

What does the Minor do with unstructured time?

**RELATIONSHIP CONCERNS**

- Problems with other kids
- Problems with Parents
- Problems with Parent's Divorce
- Problems with Teachers

- Problems with Siblings
- Problems with Step-Parent
- Problems with Step-Siblings
- Problems with Grandparents

- Problems with Parent Dating
- Problems with Sibling Moving Out
- Problems with Grades/Learning
- 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?