

Bridge Counseling Group, MFC #39867
5006 Sunrise Blvd, Suite 104
Fair Oaks, CA 95628
Phone (916) 557-8881

Intake Form for Child/Adolescent Psychotherapy

Child's name: _____ DOB/Age: _____ / _____

Child primarily lives with: Both Parents Mother Father Other: _____

Mother's name: _____ DOB: _____

Address: _____

Phone: Mobile: _____ Home: _____

Employer: _____

Custody: _____

Please list others living in mother's home, along with ages and relationship to child:

Father's name: _____ DOB: _____

Address: _____

Phone: Mobile: _____ Home: _____

Employer: _____

Custody: _____

Please list others living in father's home, along with ages and relationship to child:

Step-parent's/Guardian's information (if applicable): _____

Address: _____

Phone: Mobile: _____ Home: _____

Employer: _____

Who has legal guardianship of your child: _____

Please describe custody and the child's current living arrangements: _____

Is there any legal involvement with your child? Yes No If yes, please describe:

Responsible Party information:

Name: _____ DOB/Age: _____ / _____

Affiliation? (spouse, parent, etc.) _____

Who are your child's significant others **not** living with your child? Please list their names, ages, relationships, grades, and jobs, if applicable:

1. _____
2. _____
3. _____
4. _____

School attending and grade level (if applicable): _____

Child's job and employer (if applicable): _____

Work phone: _____ Work days and hours: _____

How were you referred: _____

Reason(s) for seeking therapy: _____

What goals do you have for therapy: _____

Have you sought mental health treatment before for your child? Yes No

If so, when and with whom? _____

Current medical doctor/Family physician: _____

Phone number: _____

Current medications (type and dosage): _____

Has there been any history or suspicion of physical, sexual, or emotional abuse (if so, explain) _____

Have there been any suicide attempts? (If so, explain) _____

In case of emergency, please notify:

Name: _____ **Phone:** _____ **Relationship:** _____

Please check all issues that you have observed:

- | | | |
|---|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Gender issues | <input type="checkbox"/> Co-dependency |
| <input type="checkbox"/> Eating disturbance | <input type="checkbox"/> Alcohol/drug use | <input type="checkbox"/> Sexual disturbance |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Obsessive/Compulsive |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Substance abuse (past) |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Aggressive behaviors | <input type="checkbox"/> Substance abuse (present) |
| <input type="checkbox"/> Phobias/fears | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Anger/temper |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> High stress | <input type="checkbox"/> Low energy/fatigue |
| <input type="checkbox"/> Avoidant behaviors | <input type="checkbox"/> Social skills problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Relationship issues | |