Bridge Counseling Group, MFC #39867

10940 Fair Oaks Blvd, Suite 100
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:

__ Depressed mood	__Gender issues	__Co-dependency
__Eating disturbance	__Alcohol/drug use	__Sexual disturbance
__Physical abuse	__Sleep disturbance	__Obsessive/Compulsive
__Hallucinations	__Sexual abuse	__Substance abuse (past)
__Low self-esteem	__Aggressive behaviors	__Substance abuse (present)
__Phobias/fears	__Suicidal thoughts	__Anger/temper
__Chronic pain	__High stress	__Low energy/fatigue
__Avoidant behaviors	__Social skills problems	__Other _____
__Panic attacks	__Relationship issues	