BRIGHTER DAY THERAPEUTIC SOLUTIONS, PLLC

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Child/Adolescent Intake Form

Client Identifying Information

Name of Child/Adolescent: _____ Sex: Male ____ Female _____

Birth Date: _____ Place of Birth: _____ Age: _____

Race/Ethnicity: _____ Religion: _____

Address (number and street): _____

City: _____ State: _____ Zip Code: _____

Present School: _____ Education (grade): _____

Parent/Guardian/ Custodian Information

Name: _____ Relationship: _____

Home Phone: _____ May we leave a message? Yes ____ No ____

Cell Phone: _____ May we leave a text/message? Yes ___ No ___

E-mail: _____ May contact you via email? Yes_____ No _____

*Please be aware that email might not be confidential

Emergency Contact: _____ Phone: _____ Relationship:_____

Current Symptom Checklist **(please circle all that apply):** Anger Problems Behavioral/Conduct Problems Anxiety Depressed Mood Mood Swings Trauma Body Image Problems ADHD: Poor Concentration/Hyperactivity Impulsive Behaviors Suicidal Thoughts Suicidal Attempts Homicidal Thoughts Hallucinations Adjustment Issues Sexual Abuse Physical Abuse Emotional Abuse Neglect _____ _____

Primary Concern: _____ Referral Source: _____

Reason for seeking mental health/behavioral health treatment: _____

Has your child ever had suicidal thoughts or plan?: _____ Yes _____ No

Has your child ever attempted suicide? _____ Yes _____No If yes, last attempt:_____

Has your child been investigated/accused of/charged with a crime against another minor?: __Yes __No

Has your child had previous psychotherapy or other mental health treatment? _____ Yes _____No

If yes, explain:

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____