Brightside Counseling Services, LLC

12835 E. Arapahoe Road
Suite 2-440
Centennial, CO 80112
303-353-9226
www.brightsidecounseling.net

Child/Adolescent Registration Form

Today's Date:	Therapist:

Referral Source: ❑ Psychology Today ❑ Good Therapy ❑ Google Search Term_____
❑ Person (who)_____ ❑ Other _____

Primary Reason for coming in:

CLIENT INFORMATION

Child's Legal Last name:	First name:	Middle name:	Date of birth:	Age:	Social Security Number

Address:	PO Box/Apt. no:	City:	State:	Zip code:

Child's home phone no.:	Child's cell phone no.:	Child's email address:

Racial/ Ethnic Origin:
❑Latino/a ❑African ❑Caucasian
❑African American ❑Middle Eastern
❑Asian/Pacific Islander ❑Alaska Native
❑Native American/Indian
❑Multicultural_____
❑ Other_____
❑ I would not like to disclose

Spiritual/Religious Affiliation:
❑Catholic ❑Protestant ❑Muslim ❑Hindu
❑Buddhist ❑Jewish ❑Atheist ❑ Islam
❑Mormon ❑Baptist ❑Episcopal ❑Lutheran
❑Methodist ❑Presbyterian
❑Chinese Traditional ❑ Non-Denominational
❑Other: _____
❑ I would not like to disclose

Are you currently practicing your religion?

❑Yes ❑No ❑I would not like to disclose

Sexual orientation:
❑Straight/Heterosexual
❑Gay/Homosexual
❑Bi/Bisexual
❑Transgender M to F F to M
❑Not sure
❑Other_____
❑I would not like to disclose

Current Living Situation:
❑Both parents together ❑ Both parents separately
❑Single parent with visitation
❑Single parent with no visitation ❑Blended family
❑Foster or Adoptive family ❑Group home
❑Emancipated
❑ Other_____
❑ Relevant info. Regarding this: _____
_____
_____

Have you experienced any of the following? Check all that apply:
❑Developmental delay/disability ❑ADD/ADHD ❑Learning difficulties
❑Behavioral problems ❑Legal problems ❑History of physical abuse
❑ Low self esteem ❑Depression ❑History of sexual abuse ❑Suicidal
❑Substance use/abuse ❑Self harm ❑Hospitalization for mental health
❑Death ❑Health problems ❑Fears ❑Anger ❑Relationship problems
❑Social problems ❑Sadness ❑Nightmares ❑Family problems ❑Divorce
❑Autism/Asperger's
❑ Other_____
❑ Relevant info. Regarding this: _____
_____
_____

Primary care physician:	Primary care physician phone no.:	Last visit:	Length of time with PCP:

Have you been in therapy before? If yes, with who?:	Do you have a psychiatrist? If yes, who?	Psychiatrist's phone no.:

List any Medications you are taking (OTC or Prescribed) and what it's treating:

	Medication/dose:	Treating:
1.		
2.		
3.		
4.		
5.		

List family (parents, children, siblings):

	Relative:	Age:	Living with you?:
1.			
2.			
3.			
4.			
5.			

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LEGAL GUARDIAN INFORMATION

Last name:	First name:	Middle name:	Date of birth:	Age:	Social Security Number

Address:	PO Box/Apt. no:	City:	State:	Zip code:

Occupation:	Employer:	Length at job:	Email address:

Work phone no.:

Cell phone no.:

Home phone no.:

Racial/ Ethnic Origin:
❑Latino/a ❑African ❑Caucasian
❑African American ❑Middle Eastern
❑Asian/Pacific Islander ❑Alaska Native
❑Native American/Indian
❑Multicultural_____
❑ Other_____
❑ I would not like to disclose

Preferred way to be contacted:
❑ Cell ❑Home ❑Work ❑ Mail ❑ Email

Can I leave a message?: Can I send you a text?:
❑Yes ❑No ❑Yes ❑No

Spiritual/Religious Affiliation:
❑Catholic ❑Protestant ❑Muslim ❑Hindu
❑Buddhist ❑Jewish ❑Atheist ❑ Islam
❑Mormon ❑Baptist ❑Episcopal ❑Lutheran
❑Methodist ❑Presbyterian
❑Chinese Traditional ❑ Non-Denominational
❑Other: _____
❑ I would not like to disclose

Are you currently practicing your religion?

❑Yes ❑No ❑I would not like to disclose

Relationship status:
❑Single ❑Married
❑ Divorced ❑Widowed
❑ Separated
❑ Cohabitating partner
❑Non-cohabitating partner
❑Other_____

Name of partner/wife/husband:

Sexual orientation:
❑Straight/Heterosexual
❑Gay/Homosexual
❑Bi/Bisexual
❑Transgender M to F F to M
❑Not sure
❑Other_____
❑I would not like to disclose

Relationship to client:
❑Mother ❑Father ❑Step parent
❑Foster Parent ❑Adoptive Parent
❑Legal Guardian ❑Relative: _____
❑Other: _____

Any other detail that you would like to share?:

ADDITIONAL GUARDIAN INFORMATION

Last name:	First name:	Middle name:	Date of birth:	Age:	Social Security Number

Address:	PO Box/Apt. no:	City:	State:	Zip code:

Occupation:	Employer:	Length at job:	Email address:

Work phone no.:

Cell phone no.:

Home phone no.:

Preferred way to be contacted:
❑ Cell ❑Home ❑Work ❑ Mail ❑ Email

Can I leave a message?: Can I send you a text?:
❑Yes ❑No ❑Yes ❑No

Sexual orientation:
❑Straight/Heterosexual
❑Gay/Homosexual
❑Bi/Bisexual
❑Transgender M to F F to M
❑Not sure
❑Other_____
❑I would not like to disclose

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IN CASE OF EMERGENCY		
Name a local friend or relative (please have one not living with you): 1.	Relationship:	Phone no.:
2.		