Redemption KC

To be completed by the Adolescent

GENERAL:

Full Name:

Name You Prefer:

Address: City: Zip:

Sex:____Male _____Female Birth Date:_____ Age:_____ Grade:_____

Phone: Email:

Name of Parent(s)/Guardian: _____

Who are you presently living with?_____

School:_____ Job (if none, leave blank)_____

Work hours per week:_____

What are your hobbies/interests?

Do you believe in God? _____Yes_____No

Fill in the blank: God is

Please describe why you are coming to counseling (i.e. what are the problems that you want help with)?

MEDIA/PHONE USE:

Do you have your own cell phone? _____NO _____YES

If yes, what social media accounts/platforms do you currently use? (Facebook, Instagram, MySpace, Snapchat,etc.?)

How much time per day (on average) do you spend on your social media accounts?

PROBLEMS CHECKLIST

Please rate each issue: **1** = Major Problem **2** = Sometimes a Problem **3** = Never a Problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Getting a clear sense of what I value

_____ Worrying about whether I'm normal

_____ Excessive worry or anxiety

_____ Dealing with my alcohol or drug abuse

_____ Never eating/eating too much and vomiting to control weight

_____ Trying to decide on a career

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Dealing with sexual feelings and/or problems

_____ Getting along with my parents or other family members

_____ Feeling bad about the way I look/my body

Have you been to a counselor/psychiatrist in the past? _____

If 'yes,' when and for how long?_____

What was ***helpful*** about that counseling experience?

What was ***unhelpful*** about that counseling experience?

Are there any other problems or concerns you would like to address in counseling?

To Be Completed by the Parent/Guardian

Parent's full name_____

Parent's Phone_____Parent's Email: _____

How would you prefer to receive session reminders and resources?

Text____ Email_____ Phone message_____

With whom does your child currently live? (Check all that apply)

_____Parent(s) ____Grandparent(s) ____ Alone _____Sibling(s) _____Boyfriend ____Girlfriend _____Roommate

List your child's mother, father, brothers, sisters, stepfamily relations, or any other family member who had/has a significant effect (positive or negative) on his/her life.

Name	Current Age or Year of Death	Relationship to the Child	Describe Person in 2-3 Words

Please add additional pages if needed

MEDICAL INFORMATION FOR CHILD

Is your child currently receiving medical treatment: ____Yes ____No

If 'yes,' please specify: _____

List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments your child has had:

List **all current** medications your child is taking, including those seldom used or taken only as needed:

Medication: _____Dosage: ____ ____

□ Improves □ Prevents □ Controls: _____

Medication: _____ Dosage: ____ ____

□ Improves □ Prevents □ Controls: _____ ____

Is your child taking these medication(s) according to a doctor's recommendations: □ Yes □ No.

If no, briefly explain:

PHYSIOLOGICAL SYMPTOMS NOTED CONCERNING CHILD: Please check any of the following physiological symptoms/sensations that apply presently or in the recent past:

Present	Past		Present	Past	
____	____	Headaches	____	____	Weakness
____	____	Dizziness	____	____	Tension
____	____	Stomach Trouble	____	____	Rapid Heart Rate
____	____	Visual Trouble	____	____	Difficulty Breathing
____	____	Sleep Trouble	____	____	Intestinal Trouble
____	____	Trouble Relaxing	____	____	Hearing Noises
____	____	Change in Appetite	____	____	Hearing Voices
____	____	Tiredness	____	____	Seeing Things
____	____	Pain	____	___ _	Other (specify) _____

Is your child presently experiencing any suicidal thoughts? ____Yes ____No

Has he/she experienced them in the past? ___Yes ___No If 'yes,' when? _____

Has he/she ever attempted suicide? ___Yes ___No If 'yes,' when? _____

Has/have any of his/her friends or family ever committed or attempted suicide? ____Yes ____ No

If 'yes' how long ago did this occur? Please include any related information we should be aware of.

Is your child presently experiencing any thoughts of harming another person? ___Yes ___No

CURRENT STATUS OF CHILD: Please check any of the following problems which pertain to your child and/or your family:

_____Stress
_____Anxiety or worry
_____Panic
_____Depression
_____Crying all the time
_____Lack of motivation
_____Fatigue/Lack of energy
_____Poor appetite
_____ Overeating
_____Poor concentration
_____Feeling worthless
_____ Feeling inferior
_____Feeling hopeless
_____Guilt
_____Death of a loved one
_____Grief
_____Chronic pain
_____Physical disability
_____Terminal illness
_____Health concerns

_____Loneliness
_____Fears
_____Shyness
_____Low self-esteem
_____Don't like myself
_____Marital problems
_____Other relational problems
_____ Parenting problems
_____Physical abuse
_____Emotional abuse
_____ Verbal abuse
_____ Sexual abuse
_____Sexual problems
_____Anger
_____Aggressive behavior
_____Bad dreams
_____Unwanted memories
_____ Loss of control
_____ Impulsive behavior

_____Controlling
_____Controlled by others
_____Obsessive thoughts
_____Compulsive behaviors
_____Racing thoughts
_____Eating problems
_____Drug use
_____Alcohol use
_____ Pregnancy
_____Abortion
_____Legal matters
_____ Work stress
_____Career choices
_____ Indecisiveness
_____Lack of discipline
_____Financial problems
_____ Spiritual apathy
_____Other
Specify_____

FAMILY ACTIVITIES:

How often does your family have dinner together? _____Do activities together?_____ What activities do you enjoy doing as a family?

What time is your child's curfew on school nights?_____ Weekend Nights? _____

Do you give your child specific chores around the house? □ No □ Yes (please specify)

If your child does not follow the rules or disobeys, what are the consequences for his/her behavior?

CHILD'S SCHOOL INVOLVEMENT

Is your child in any advanced classes this year? □ No □ Yes _____ What grades did your child get on his/her last report card?

If your child is failing classes, how many classes and which ones?

This Year_____ Last Year: _____

Has your child had a discipline problem at school?

This Year_____ Last Year: _____

Describe:

Does your child like school? □ Yes □ No

How regularly does your child attend school? □ Every day □ Most days □ Some days □ Never

Does your child/adolescent have friends?

□ Yes, I have met most of them □ Yes, but I have never met them □ My child does not talk about his/friends □ No friends at all

Is your child involved in any extracurricular activities? □ Yes □ No If Yes, what: _____

CHILD'S PERSONALITY: In a few sentences describe your child's personality, including strengths/weaknesses.

CURRENT ISSUES AND GOALS Please describe why your child is coming to counseling (i.e. what are your child's issues, struggles?):

How long has he/she had this problem/struggle?

How long do you believe counseling should last?

What do you hope to gain or change by providing counseling for your child?

PREVIOUS COUNSELING: List any previous Counseling, Psychiatric Treatment, or Residential/In Patient Care your child has received:

Therapist: _____ Dates: _____ Reason: _____

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FAITH BACKGROUND

Do you regularly attend a place of worship: □ Yes □ No.

If 'yes,' where:

What is the name of your pastor?

Any recent changes in your faith habits, community, or beliefs that would be helpful to know?

FAMILY SUPPORT

Do you have a personal support system: □ Yes □ No.

If 'yes,' who and how often/what type of support?

Is there anything else we should know that would enable us to better support your child?

Consent for Biblical Counseling for Minors

I, _____ (guardian name), represent that I have legal authority to obtain biblical counseling for any minor child/children entrusted to my care, and grant consent for R:KC to provide counseling services to my minor child:

_____(Child's full name)

Parent Signature _____