Christian Counseling Services

Minor Intake Assessment and Consent Form

Please complete this form prior to first session

General Information

Client's Name: _____ DOB: _____ Age: _____

Gender: Male ☐ Female ☐

Address: _____ City: _____ State: _____ ZIP: _____

Parent/Guardian Name (1) _____ Relationship: _____

Parent/Guardian (1) Phone Number(s): Home _____ Cell _____

Work _____ Other _____

Parent/Guardian (1) email: _____

OK to leave message *(check all that apply)*: Home ☐ Cell ☐ Work ☐ Other ☐ Email ☐

Parent/Guardian Name (2) _____ Relationship: _____

Parent/Guardian (2) Phone Number(s): Home _____ Cell _____

Work _____ Other _____

Parent/Guardian (2) email: _____

OK to leave message *(check all that apply)*: Home ☐ Cell ☐ Work ☐ Other ☐ Email ☐

Custody Terms (if applicable*): Does not apply ☐

_____

_____

*If there are formal custodial arrangements, please bring appropriate court documentation to first session.

Referral Information

How did you hear about Christian Counseling Services? _____

Services Needed: Child/Adolescent Therapy ☐ Family Therapy ☐ Medical Referral ☐

Person completing this packet: Parent ☐ Foster Parent ☐ Legal Guardian ☐ Client ☐ Other ☐

Please describe the main problem/reason for seeking therapy: _____

_____

_____

_____

_____

What changes or improvements are expected with treatment? _____

_____

_____

_____

Emergency Contact

Primary

Name: _____ Relationship: _____

Phone Number: _____ Is this person allowed to pick up the client? Yes ☐ No ☐

Secondary

Name: _____ Relationship: _____

Phone Number: _____ Is this person allowed to pick up the client? Yes ☐ No ☐

Is there anyone else you wish to use as an emergency contact and/or client pick up?

_____

_____

I confirm that the information contained in these forms is true and correct to the best of my knowledge.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Presenting Problem Checklist (Please indicate all concerning behaviors):

Issue	**Past**	**Present**	**Issue**	**Past**	**Present**
Crying, sadness, depression			Temper tantrums/outbursts		
Lost enjoyment in usual activities			Irritability/anger		
Tiredness/fatigue			Excessive arguing		
Anxiousness/nervousness			Disobedience/defiance		
Panic attacks			Intentionally annoying to others		
Excessive worry			Gets annoyed easily		
Low self-esteem			Aggressive behavior/fighting		
Withdrawn			Impulsive/acts without thinking		
Change to sleep patterns			Negative thoughts		
Nightmare/night terrors			Blames others/refuses responsibility		
Sleepwalking			Refusal to complete chores		
Poor bladder control/bedwetting			Intentionally hurts people or animals		
Change in eating patterns/appetite			Intentionally destroys property		
Preoccupied with weight/size			Uses inappropriate language/swears		
Extreme weight loss or gain			Inappropriate sexual behavior		
Usual fears or phobias			Accesses pornography		
Headaches/stomachaches			Threatened/attempted running away		
Twitches or involuntary tics			Sneaking out		
Hallucinations			Academic decline		
Has rituals, habits, superstitions			Lack of motivation		
Repeats unnecessary behaviors			Easily distracted		
Poor hygiene or self-care habits			Trouble concentrating		
Self-injury			Fidgeting/excessive activity		
Homicidal thoughts			Cannot complete tasks		
Preoccupied with death			Disruptive		
Suicidal thought(s)/attempt(s)			Questioning sexual orientation		
Lying			Physical Abuse		
Stealing			Sexual Abuse		
Problem with authority			Emotional/Mental/Verbal Abuse		
Legal issues			Drug/alcohol use		

Additional behavioral or emotional concerns/symptoms _____

_____

_____

Please describe the most important/distressing symptoms (Severity = 1-10):

Symptom #1: _____

Severity: _____ Frequency: _____ Duration: _____

Symptom #2: _____

Severity: _____ Frequency: _____ Duration: _____

Symptom #3: _____

Severity: _____ Frequency: _____ Duration: _____

Symptom #4: _____

Severity: _____ Frequency: _____ Duration: _____

What are some of the client's strength? _____

_____

What are some of the client's weaknesses? _____

_____

If abuse is indicated, please provide additional details (dates, locations, offenders, impact to family/client, action taken): N/A ☐ _____

_____

_____

If self-harm, suicide, or homicide is indicated, please provide additional details (threat, victim, action taken, timeline, etc.): N/A ☐ _____

_____

_____

Does the client have a current intent/active plan for harm to themselves or someone else? Yes ☐ No ☐

Developmental History:

Please indicate any complications related to the pregnancy, labor, and birth of the client:

Mother used drugs		Health problems during pregnancy		Premature birth	
Mother used alcohol		Problems with labor		Admitted to NICU	
Mother was on bed rest		Problems with delivery		Born with cord around neck	

As an infant/toddler, please indicate any difficulties the client experienced in the following areas:

Eating/feeding self		Turning over		Crawling/walking	
Toilet training		Language development		Sleeping thought the night	
Following basic commands		Separating from parents		Interacting with other children	

Please describe: N/A ☐ _____

_____

_____

Pleased describe any major health issues the client had up to five (5) years old (such as seizures, severe colic, organ defects, injuries, major infections, etc.): N/A ☐

Issue	**Age**	**Outcome**

Was the client breast fed? Yes ☐ No ☐

Is the client a multiple? Yes ☐ No ☐

Please rate the client's activity level up to age five (5):

Very Active ☐ Active ☐ Average ☐ Limited ☐ Inactive ☐

Approximately how long did toilet training take? _____

Family History

Please indicate all members in the client's immediate family.

Name	Age	Relationship	Living at home (Y/N)	Occupation/Grade

Current living situation: _____

_____

Previous living situation (previous year): _____

_____

Does the client live in a single-parent household?: Yes ☐ No ☐

Does the client live with a blended family?: Yes ☐ No ☐

Specify the overall level of family conflict: High ☐ Moderate ☐ Low ☐

How well does the client get along with his/her siblings?: _____

_____

With which family member is the client the closest?: _____

Which family relationships are tense/distant/negative?: _____

_____

_____

Are there any current marital problems that could be affecting the client?: Yes ☐ No ☐

If yes, please describe: _____

_____

What are family strengths?: _____

_____

What are family weaknesses?: _____

_____

Is there any history of the following in the past two biological generations (continue on back if needed)?

Issue	**Person**	**Comments**
Mental Illness		
Abuse		
Addiction		
Learning Disabilities		
Birth Defects		
Significant Legal Issues		

What type of discipline is used at home?

Type	**Frequency**	**Effectiveness (1-10)**	**Administered by**
Verbal reprimand			
Time out/Isolation			
Removal of privileges			
Rewards			
Physical punishment/spanking			
Natural consequences			
Threats/warnings			
Giving in or avoiding confrontation			
Emotion coaching			

Please indicate the following regarding family dynamics:

Our family is warm and loving Yes ☐ No ☐

Family members are respectful to one another Yes ☐ No ☐

Our home is very chaotic Yes ☐ No ☐

Our family feels connected Yes ☐ No ☐

Our home has a lot of conflict Yes ☐ No ☐

How has the family been impacted by the client's issue(s)?: _____

_____

_____

In what ways is the family willing to be involved by the client's treatment?: _____

_____

_____

What is the role of any other family member(s) in the client's problem(s)?: _____

_____

_____

Social History

Please indicate the items that describe the client in social situations:

Prefers to be alone		Few friends/feels lonely	
Shy/withdrawn		Many friends/popular	
Outgoing/friendly		Poor personal boundaries	
Gravitates toward "problem kids"		Has inappropriate interactions with others	
Is oversensitive/easily offended		Gets teased/bullied	
Physical fights with others		Teases or bullies others	
Poor peer relationships		Frequent conflict with others	
Difficulty sharing or negotiating with others		Tends to be demanding or bossy	
Makes friends easily		Shows good manners/respects others	

Please describe client's personality with a few adjectives: _____

_____

Is the client generally comfortable is social situations?: Yes ☐ No ☐

Has the client completed puberty?: Yes ☐ No ☐

Please describe any age-inappropriate sexual activity or behaviors that have been observed: _____

_____

Client relationship status: Single ☐ In a relationship ☐ "It's complicated" ☐ N/A ☐

If a relationship is indicated, please indicate duration: _____

Is client sexually active?: Yes ☐ No ☐ Not sure ☐

If yes, are birth control methods being utilized?: Yes ☐ No ☐ Not sure ☐

Does the client display any signs of sexual orientation or gender identity issues?: Yes ☐ No ☐

If yes, please explain: _____

_____

Is there any other important information regarding the client's sexual maturation, activities, or health?

_____

_____

_____

Medical/Treatment History

Please indicate client's major health problems and/or surgeries:

Condition	Yes	Age	Details
Serious infections			
Major surgeries			
Extended hospitalizations			
Significant injuries			
Allergies			
Drug abuse/addiction			
Sexually transmitted disease			
Chronic illness			
Genetic disorders			

Additional comments: _____

_____

_____

_____

Please indicate any medications the client is taking:

Medication	Dosage/Duration	Purpose

Has the client ever had mental health treatment before? (Continue on back if needed.)

Provider	Reason/Services	Purpose

Has the client ever been hospitalized for psychiatric issues? Yes ☐ No ☐

Has the client ever been admitted for residential/in-patient treatment? Yes ☐ No ☐

Has the client ever been seen by a psychiatrist/psychologist? Yes ☐ No ☐

When was the last time the client was assessed by a General Practitioner? _____

Does the client complain of frequent aches or pains? Yes ☐ No ☐

If yes, please describe: _____

_____

School/Academic History

Name of school: _____ Institution type: _____

Grade (current or highest completed): _____ Average performance (grades A-F): _____

Does the client have a diagnosed learning disability? Yes ☐ No ☐

If yes, please specify: _____

Treatment/Action plan: _____

If yes, does the school have an Individual Education Plan (IEP)? Yes ☐ No ☐

If yes, what are the current accommodations? _____

_____

Has the client ever attended a special education program? Yes ☐ No ☐

If yes, please describe type and duration: _____

_____

Please check any significant education issues:

Issue	**Yes**	**Grade**	**Issue**	**Yes**	**Grade**
Disruptive in class			Tutoring needed		
Oppositional with teachers			Detention		
Failure to complete/submit work			Suspension/expulsion		
Refusal to go to school			Poor relationship w/ teacher(s)		
Excessive absences/truancy			Repeated grade levels		

Please clarify: _____

_____

_____

Please summarize the client's general progress in school (including academic performance, social behaviors, testing, significant accomplishments, extracurricular activities, etc.): _____

_____

_____

_____

Current Stressors

Please indicate any major changes that have occurred in the family/home environment in the last 12 mos.

Stressor	**Impact (1-10)**	**Stressor**	**Impact (1-10)**
Financial problems		Mental illness diagnosis	
Recent/frequent moving		Major illness/hospitalization	
Divorce/Separation		Legal problems	
Remarriage		Onset of drug or alcohol use	
Separation from siblings		Probation	
Job change		Loss of friend/relative/pet	
Significant change in routine		Observed or experienced abuse	
Marital problems/parental conflict		Housing problems	
Adoption/foster care		Custody battle	

Please clarify: _____

_____

_____

_____

_____

Additional comments: _____

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_____

Christian Counseling Services

Consent for Treatment of a Minor

To be signed by all parents and/or legal guardians

I/we _____ ,
the parent(s)/legal guardian(s)of _____, age _____
(hereinafter referred to as "the minor"), give authorization and consent for Christian Counseling Services to provide counseling to the minor.

Authorization and consent are given with the understanding that, although rare, there are potential risks associate with counseling children under the age of 18. I/we fully understand these potential risks and choose to allow the minor to participate in counseling. I/we release Christian Counseling Services from any liability for discomfort related to counseling services provided.

I/we have read and fully understand this authorization and release form. I/we understand that this form should not be signed if I/we do not fully understand or if all my/our questions have not been answered satisfactorily.

Printed Name: Printed Name:

_____ _____

Signature: Signature:

_____ _____

Date: Date:

_____ _____