Christian Counseling Services

Minor Intake Assessment and Consent Form

*Please complete this form before the first session

General Information:

Client's Name: _____ DOB and Age: _____

Gender: Male ( ) Female ( )

Full Address: _____

Parent/Guardian Name (#1): _____ Relationship: _____

Parent/Guardian Name (#2): _____ Relationship: _____

Parent's Phone Number: _____ (CELL / HOME)

Is it OK to leave messages?: Text (YES / NO) Voicemail (YES / NO)

Parent's Email Address: _____

Custody terms (if applicable)*: NA ( ) _____

_____

* If there is a formal custody arrangement, please bring the appropriate court documentation to the first session.

Referral Information:

How did you hear about Christian Counseling Services? _____

Type of services needed: Child/Adolescent Therapy ( ) Family Therapy ( ) Medical Referral ( )

Who completed this packet?: Parent ( ) Foster Parent ( ) Legal Guardian ( ) Client ( ) Other ( )

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

_____

_____

_____

What changes or improvement is expected after treatment?: _____

_____

_____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number _____ Is this person allowed to pick up the client? Yes ( ) No ( )

I attest that the information contained in this packet 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Withdrawn			Impulsive/acts without thinking		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		

Other 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 strengths?: _____

_____

What are some of the client's weaknesses?: _____

_____

If abuse was indicated, please provide additional details (dates, locations, perpetrators, impact to client/family, action taken): NA ( ) _____

_____

_____

If self-harm, suicide, or homicide was indicated, please provide additional details (threat, victim, action taken, timeline, etc.): NA ( ) _____

_____

_____

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: NA ( ) _____

_____

_____

Please describe any major health issues the client had up to 5 years old (such as seizures, severe colic, organ defects, injuries, major infections, etc.): NA ( )

Issue	**Age**	**Outcome**

Was the client breastfed? Yes ( ) No ( )

Is the client a multiple? Yes ( ) No ( )

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

Very active ( ) Active ( ) Average ( ) Less active ( ) Not active ( )

Approximately how long did toilet training take?: _____

Family History:

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

Name	Age	Relationship	In the home? (Y/N)	Occupation/Grade

Current living situation: _____

Previous living situation (past 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 sibling(s)? _____

With which family member is the client 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 the family's strengths? _____

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

Issue	Who	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 reprimands			
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 about the family's 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 problem(s)?: _____

_____

_____

In what ways is the family willing to be involved in 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 towards "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 the client's personality with a few adjectives: _____

_____

Is the client generally comfortable in 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" ( ) NA ( )

If a relationship was indicated, please indicate length: _____

Is the client sexually active? Yes ( ) No ( ) Not sure ( )

If yes, are birth control methods being utilized? Yes ( ) No ( ) Not sure ( )

Does the client show 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 the client's major health problems or surgeries:

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

Other Comments: _____

_____

_____

Please indicate any regular medication the client is taking (especially psychiatric medication):

Medication	Dose/Duration	Purpose

Has the client ever had mental health treatment before? (Please continue on the back, if needed):

Provider	Reason/Services	Outcome

Has the client ever been hospitalized for psychiatric issues: Yes ( ) No ( )

Has the client ever been admitted for residential treatment: Yes ( ) No ( )

Has the client ever been seen by a psychiatrist? Yes ( ) No ( )

When was the last time that 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 established 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 educational issues:

Issue	Yes	Grade		Yes	Grade
Disruptive in class			Tutoring needed		
Oppositional with teachers			Detention		
Failure to complete or submit work			Suspension/Expulsion		
Refusal to go to school			Poor relationships with teacher(s)		
Excessive absences/truancy			Repeated grades		

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 months:

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

Please clarify: _____

_____

_____

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.

This authorization and consent is given with my understanding that, although rare, there are potential risks associated with counseling children under 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:

_____

Signature:

_____

Date: _____

Printed name:

_____

Signature:

_____

Date: _____