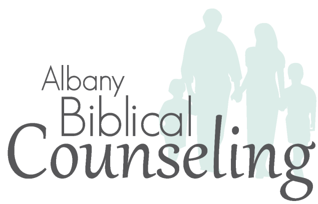


ADOLESCENT INTAKE FORM (13-17)

Date:_______________________

PERSONAL INFORMATION

TO BE COMPLETED BY THE STUDENT

Name ____ E-mail ____________________________________

Street Address ____

City ____ State _________________ Zip _____________________

Sex __________ Birth Date _________________ Age _______ Weight ___________ Height ______________

Cell Phone __________________________ Parent/ Guardian's Phone _________________________

Were you raised by anyone other than your own parents? ❑ Yes ❑ No If "Yes," who?___________________

Please explain. ____

Who are you living with right now?____

School ____ Grade _______________________________________

Hobbies/Job ____

I was referred to The Biblical Counseling Center by ____

RELIGIOUS BACKGROUND

What church do you currently attend? (List the name and city)

____

Pastor's Name _______________________ Phone _______________ E-mail _____________________________

Have you been baptized? ❑ Yes ❑ No; When? ____

How do you characterize your relationship to Jesus? ❑ None ❑ Struggling ❑ Growing ❑ Strong

How often do you read the Bible? ❑ Never ❑ Seldom ❑ Often

Do you pray to God? ❑ Never ❑ Seldom ❑ Often

Have you come to the place in your spiritual life where you can say that you know for certain that if you were to die today you would go to heaven? Explain. ____

____

*Approximately how many hours of sleep do you get each night? _____________________________________

*When do you usually: Go to sleep? __________ Fall asleep? ____________ Get out of bed? ______________

*If you have trouble sleeping, do you know what might be the reason? ________________________________

____

*How would people characterize the kind of person you are? ____

____

Albany Biblical Counseling

ADOLESCENT INTAKE FORM (13-17)

Date:_______________________

PERSONALITY INFORMATION

Have you had any kind of counseling before? ❑ Yes ❑ No

*If yes, please explain a little about it. ____

____

Problems Checklist

Please rate each Issue with a number: 1 = Major Problem 2= Sometimes a problem 3= Never a Problem

______ Feeling accepted by my peers
______ Learning how to trust others
______ Feeling bad about the way I look/my body
______ Getting along with my parents or other family members
______ Getting a clear sense of what I value
______ Worrying about whether I'm normal
______ Dealing with sexual feelings and/or problem
______ Excessive worry or anxiety
______ Trying to decide on a career
______ Never eating/eating too much and/ or vomiting to control weight
______ Dealing with my drinking, drug abuse or smoking
______ Dealing with problem at school
______ Dealing with how I feel about myself

Have you ever had a severe emotional upset? ❑ Yes ❑ No; if "yes," please briefly describe.

____

Have you ever been arrested? ❑ Yes ❑ No; if "yes," please briefly describe the outcome.

____

***Please check the appropriate response:**

Have you ever felt people were watching you? ❑ Yes ❑ No
Have you ever had hallucinations? ❑ Yes ❑ No
Are you sometimes unable to judge distances? ❑ Yes ❑ No
Are you afraid of being in a car or airplane? ❑ Yes ❑ No

*Is ❑ self or ❑ girlfriend pregnant? ❑ Yes ❑ No; **if "yes,"** please briefly describe how far along.

____

*Has ❑ self or ❑ girlfriend ever had an abortion? ❑ Yes ❑ No; **if "yes,"** please briefly describe the circumstances. ____

*Does ❑ self or ❑ girlfriend have an STD? ❑ Yes ❑ No; **if "yes,"** please give approximate time-line of contraction. ____

*Has ❑ self or ❑ girlfriend ever been sexually molested? ❑ Yes ❑ No; **if "yes,"** please give approximate time-line of incident(s). ____

Albany Biblical Counseling

ADOLESCENT INTAKE FORM (13-17)

Date:________________________

BASIC ISSUES IDENTIFICATION
(Briefly answer the following questions. Use back if necessary.)

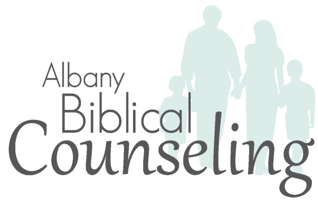
1. What do you feel is the issue that brings you here?

2. What have you done about it?

3. What are you seeking (and expecting) from biblical counseling?

4. Who do you consider a friend who has talked with you about what you are going through?

5. Is there any other information that you think we should know, any problems or concerns you would like to address?



Consent for Counseling Minors

Name of Parent/Guardian ____

Name of Minor ____

Minor's DOB ______________________________ Name of Counselor _________________________

Thank you for your involvement with Albany Biblical Counseling. It is our hope that this ministry will be a great source of encouragement to you and your family. The focus of this ministry is to use God's Word to help the counselee grow and change.

Our counselors are here to benefit the counselee by focusing on the heart issues with which they are dealing. The counselor helps to equip them to think and act in a way that would please Christ, thus benefitting family, school and friends with their change of behavior.

For minors to get the best chance to change and to grow, parents/guardians have to be committed to our process. By signing this, you state you are legal parent /guardian and agree to participate. List all who will be able to participate in counseling with this minor.

Name: _________________________________ Relationship: _________________________

Name: _________________________________ Relationship: _________________________

Name: _________________________________ Relationship: _________________________

I understand the above policy and agree to abide by it.

_______________________________________ _______________________

Parent/Guardian Signature Date

Parent/ Guardian address: ____

Home # ______________________ Cell # ______________________ Work # ______________________

Emergency Contact (Other than yourself)

Name ____ Phone ______________________

________________________________ _______________________

Center Representative Date

Albany Biblical Counseling

PARENT/TEACHER OBSERVATIONS

Date:________________________

This is a Behavior Report to be filled out by a parent/guardian or teacher (to the best of your knowledge) to help the counselor to be most effective in helping the counselee deal with the problem(s) as stated.

Person completing report: ___________________________ Are you parent, guardian or teacher? __________

CHILD'S INFORMATION

Name ____ Who does the child live with? ________________

Street Address ____

City _______________________________________ State _________________ Zip _____________________

Sex __________ Birth Date _________________ Age _______ Weight ___________ Height ______________

School ____ Grade _________________________________

Hobbies/Job ____

Does child have a cell phone? ❑ Yes ❑ No

Name the types of social media in which he or she is allowed to participate. _____________________________

Names of online games he or she plays ____

How much screen time does he or she have each day? ____

How long before bedtime is he or she off the screen? none, 30 minutes, 1 hour, more? ________________

What church does the child's family currently attend? (List the name and city)

____

Pastor's Name ______________________ Phone _______________ E-mail ____________________________

How would you characterize the spiritual state of your child? Please give detailed explanation. ___________

____

____

List approximately how many hours of sleep he or she gets each night? _________________________________

Time he or she usually: Goes to sleep? __________ Falls asleep? ____________ Gets out of bed? ___________

If he or she has trouble sleeping, do you know what might be the reason? ________________________________

____

How would you characterize the kind of person he or she is? ____

____

Albany Biblical Counseling

PARENT/TEACHER OBSERVATIONS

Date:_______________________

PERSONALITY INFORMATION

Has the child had any kind of counseling before? ❑ Yes ❑ No
*If yes, please explain a little about it. ____

____

Problems Checklist
As parent/guardian or teacher, please rate each issue with a number as it relates to the child:
1 = Major Problem 2= Sometimes a problem 3= Never a Problem

______ Feeling accepted by peers
______ Learning how to trust others
______ Feeling bad about the way he or she looks
______ Getting along with parents or other family members
______ Getting a clear sense of what he or she values
______ Worrying about whether he or she is normal
______ Dealing with sexual feelings and/or problems
______ Excessive worry or anxiety
______ Trying to decide on a career
______ Never eating/eating too much and/ or vomiting to control weight
______ Dealing with his or her drinking, drug abuse or smoking
______ Dealing with problems at school
______ Dealing with how he or she feels about self
_______Other ____

Have you ever noticed him or her being severely emotionally upset? ❑ Yes ❑ No; if "yes," please briefly describe.____

Has he or she ever been arrested? ❑ Yes ❑ No; if "yes," please briefly describe the outcome.

____

Is she or has she ever been pregnant? ❑ Yes ❑ No ❑ N/A; **if "yes,"** please briefly describe how far along.

____

Has she ever had an abortion? ❑ Yes ❑ No ❑ N/A; **if "yes,"** please briefly describe the circumstances.

____

Does he or she have a STD? ❑ Yes ❑ No; **if "yes,"** please give approximate time-line of contraction.

____

Has he or she ever been sexually molested? ❑ Yes ❑ No; **if "yes,"** please give approximate time-line of incident(s). ____

Albany Biblical Counseling

PARENT/TEACHER OBSERVATIONS

Date:________________________

BASIC ISSUES IDENTIFICATION
(Briefly answer the following questions. Use back if necessary.)

1. What is the issue for which he or she is coming to counseling?

2. What have they (you) done about it?

3. What are they (you) seeking (and expecting) from biblical counseling?

4. Who do you consider a friend who has talked with you about what you are going through with your child?

5. Is there any other information that you think we should know, any problems or concerns you would like to address?