

DATE: _____

Child's Name _____ E-mail _____

Street Address _____ City _____ State _____ Zip _____

Sex _____ Birth Date _____ Age _____ Weight _____ Height _____

Home Phone _____ Cell Phone _____

Education: Last completed grade (prior to college) _____

Other Education: (List type and years) _____

Parent/Guardian Information

Name _____ E-mail _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____

Occupation _____ Place of Employment _____

Marital Status (Single Going Steady Married Separated Divorced Widowed

Education: Last completed grade (prior to college) _____

Other Education: (List type and years) _____

Who is referring child for counseling? _____

Who will be participating in counseling with child? _____

PARENTS' RELIGIOUS BACKGROUND

What church (list the city) do you currently attend? _____

Are you a member? Yes No Denominational Preference _____

Church Address _____

Pastor's Name _____ Pastor's Phone _____

May we contact your pastor for information and help? Yes No

Church attendance per month (**circle one**) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩+

Church attended in childhood _____

Has your child made a Profession of Faith? Yes No When? _____

Has your child been baptized? Yes No When? _____

PERSONALITY INFORMATION

- *Has your child had any psychotherapy before? Yes No
- *Has your child had any secular counseling before? Yes No
- *Has your child had any biblical counseling before? Yes No

***If you answered yes on any of the above, please fill out the following information:**

Counselor's Name	Dates (Month & Year)	Medication Prescribed	Diagnosis Outcome
	From To		
	From To		
	From To		

***Please check any of the following words that would describe your child:**

- | | | |
|---|---|---|
| <input type="checkbox"/> Active | <input type="checkbox"/> Ambitious | <input type="checkbox"/> Ambivalent |
| <input type="checkbox"/> Calm | <input type="checkbox"/> Easy-going | <input type="checkbox"/> Excitable |
| <input type="checkbox"/> Extrovert | <input type="checkbox"/> Good-natured | <input type="checkbox"/> Hard-boiled |
| <input type="checkbox"/> Hardworking | <input type="checkbox"/> Hypersensitive | <input type="checkbox"/> Imaginative |
| <input type="checkbox"/> Impatient | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Introvert |
| <input type="checkbox"/> Leader | <input type="checkbox"/> Likeable | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Nervous | <input type="checkbox"/> Often-blue |
| <input type="checkbox"/> Persistent | <input type="checkbox"/> Quiet | <input type="checkbox"/> Self-confident |
| <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Serious |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Submissive | <input type="checkbox"/> Suspicious |

DATE: _____

HEALTH INFORMATION

Rate your child's health: Excellent Good Average Declining Other _____

Describe any recent weight changes. _____

List all important present or past illnesses, injuries and handicaps.

Do the above limit your child in any way? Yes; No; If Yes, how? _____

Date of last medical exam: _____ Report: _____

Your child's physician _____ Address: _____

Is your child presently taking medication? Yes; No; If yes, what? _____

Does your child drink alcoholic beverages: How often? _____ How much? _____

Has your child used drugs for other than medical purposes? Yes; No; If "yes," when and what did he or she use? _____

Does your child struggle with smoking? Yes; No; if "yes," how long has he or she been smoking? _____

Has your child ever been severely upset? Yes; No; if "yes," please briefly describe.

Has your child or any family member ever been arrested? Yes; No; if "yes," please briefly describe the outcome. _____

OTHER HEALTH RELATED QUESTIONS

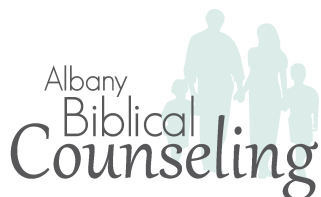
(If these questions do not apply to you, leave them blank.)

*Is your child and/or family member pregnant? Yes; No; **if "yes,"** please briefly describe how far along she is. _____

*Has your child and/or family member ever had an abortion? Yes; No; **if "yes,"** please briefly describe the circumstances. _____

*Does your child and/or family member have an STD? Yes; No; **if "yes,"** please give approximate time-line of contraction. _____

*Has your child and/or family member ever been sexually molested? Yes; No; **if "yes,"** please give approximate time-line of incident(s). _____



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