Albany Biblical Counseling

# ***CHILD INTAKE FORM (3-12)***

***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? _____

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## 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<br>To | | |
| | From<br>To | | |
| | From<br>To | | |

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

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

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## 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). _____

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

1. What do you feel is the issue that brings you here as it relates to your child?

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?

I believe the information about _____ to be true to my understanding.
(Child's Name)

_____ _____
Print Parent/ Guardian's Name Date

_____ _____
Parent/ Guardian's Signature Date

# 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