Abiding Hope Christian Counseling, Ltd.
19115 FM 2252 Ste. 12
San Antonio, TX 78266
Telephone: 210-236-7768
www.abidinghopecc.com

MINOR INTAKE FORM

PLEASE PRINT

TODAY'S DATE: _____ **HOME PHONE: _____**

NAME: _____CELL: _____

ADDRESS: _____D.O.B._____

CITY: _____STATE: _____ ZIP: _____

E-Mail address: _____

REFERRED BY: _____

SCHOOL IF STUDENT:_____ GRADE: _____

PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO MINOR: _____

Are you comfortable with the therapist praying at the end of each session? _____

Briefly list the reason for your visit? _____

_____

_____

_____

_____

Is your child presently under the care of a psychiatrist? ☐ Yes ☐ No

Is your child presently under the care of a physician? ☐ Yes ☐ No

If YES, complete authorization form on page 9.

Have they received any psychological testing? ☐ Yes ☐ No When? _____

Does your child have any medical, learning disabilities or mental health diagnoses?

_____

_____

Do they have a 504 Plan? ☐ Yes ☐ No Why: _____

Has your child been in counseling before? ☐ Yes ☐ No How long?_____

What medication is your child presently taking and for what conditions?

_____

_____

Is your child currently feeling suicidal? _____If so, do they have a plan? _____

Have they been hospitalized for suicidal ideations? _____ When? _____

Has anyone in your family completed suicide? If yes, who and when: _____

_____

Do they cut or do any other self-harm behaviors: _____

Is your child on a particular diet at this time? Please describe.

_____

_____

_____

Please indicate any of the following symptoms your child has experienced:

___ Anxiety How long? _____
___Depressed Mood How long? _____
___Low energy level How long? _____
___Racing thoughts How long? _____
___Poor concentration How long? _____
___Indecisiveness How long? _____
___ Change in sleeping How long? _____
___Change in appetite How long? _____
___Angry outbursts How long? _____
___Crying spells How long? _____
___Lack of motivation How long? _____
___Weight change How long? _____
___Feeling others are against him/her How long? _____
___Excessive guilt How long? _____
___Isolation How long? _____
___Mood swings How long? _____
___Feelings of hopelessness How long? _____
___Low self-esteem How long? _____
___Difficulty with memory How long? _____
___Thoughts/plans of suicide How long? _____
___Self-harm How long? _____
___Thoughts/plans to hurt others How long? _____
___Alcohol use How long? _____
___Drug use How long? _____
___Bedwetting How long? _____
___Soiled pants How long? _____
___Trouble in school How long? _____
___Truancy How long? _____
___Trouble with peers How long? _____
___Disobedient How long? _____
___Conflict with family How long? _____
___Running away How long? _____
___Problems with the law How long? _____
___Rocking How long? _____
___Head-banging How long? _____

___Destructive	How long? _____
___Fire-setting	How long? _____
___Harm to animals	How long? _____
___Infantile	How long? _____
___Sexual behavior	How long? _____
___Lying	How long? _____
___Over-active	How long? _____
___Fearful	How long? _____
___Impulsive	How long? _____
___Phobic	How long? _____
___Other	How long? _____
___Other	How long? _____

Bio-Psycho-Social-Spiritual History of Minor

Please describe the problem/ circumstances that led to you seeking counseling for your child:

_____

_____

_____

_____

What changes would you like to see in your child as a result of counseling?

_____

_____

_____

_____

Please list the name, age and relationship of everyone presently living with your child:

_____

_____

_____

_____

Where was your child born?

_____

Where has your child lived?

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

_____Age when living there _____ to _____

How would you describe your economic status?

___Lower class___ Middle Class ____ Upper Middle Class ____ Upper Class

In what ways has this affected your child?

_____

_____

_____

_____

Please describe your child's relationship with each of his/her parents:

Mother:

_____

_____

_____

Father:

_____

_____

_____

Siblings (age, gender, and relationship):

_____

_____

_____

Please identify any history of divorce and/ or remarriage as related to the child's parents:

_____

_____

_____

_____

Please identify any significant relationships the child has had with step-parents:

_____

_____

_____

Please describe any criminal history associated with either parents or step-parents:

_____

_____

_____

Parental military service? _____How does this impact your child?_____

_____

Was your child adopted? ☐ Yes ☐ No Do they know? ☐ Yes ☐ No

Please describe the circumstances of the adoption:

_____

_____

_____

Please describe any history of physical illness or injury in your family:

_____

_____

_____

Please describe any history of psychiatric, emotional, drug/alcohol abuse, or other problems in your family:

_____

_____

_____

_____

Have they ever experienced trauma such as domestic violence (even as a witness), sexual abuse, sexual assault, war, car accident: _____

_____

Please describe any history of sexual, physical, or emotional abuse of your child:

_____

_____

_____

_____

Has your child had any history of drug/ alcohol abuse or eating disorders?

Has your child had any history of serious illness, injury or hospitalizations? Please describe.

Has your child experienced any developmental delays? Yes / No If yes, please describe.

Were there any problems with the pregnancy or delivery of your child?

Has your child recently experienced any losses such as: a death of a loved one, loss of a job, house fire, loss of hopes or dreams, moving, deployment of a parent?

What do you perceive to be your child's greatest strengths?

What areas of your child's life do you feel need improvement most?

How would you describe the following areas: (Good, Okay, Fair, Poor)

A. Physical (exercise/nutrition) _____

B. Emotional_____

C. Spiritual_____

D. Mental health_____

E. Family_____

F. Friendships_____

G. School_____

Please describe discipline in your home and who enforces it.

_____

_____

_____

How has your child been affected by the pandemic? _____

_____

_____

_____

Did your child attend school in person or virtually in 2020? _____

How would your child's teachers describe them? _____

_____

Has your child been retained at school? ☐ Yes ☐ No What grade? _____

Is your child involved in extra-curriculars at school? _____

Please describe the role of religion and spirituality in the environment where your child lives.

_____

_____

What churches or denominations has the family primarily attended?

_____

_____

Is your child a part of a youth/church group? _____

Are you comfortable incorporating faith into the counseling process?

_____

_____

Abiding Hope Christian Counseling
Ginger Gray, LCSW Clinical Director
19115 FM 2252 Ste. 12, San Antonio, Tx 78266

Authorization for Release of Mental Health Information

I hereby authorize Ginger Gray, LCSW and Abiding Hope Christian Counseling, to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that if I do not sign this form, federal and state law will prohibit Ms. Gray and her practice from releasing records regarding her treatment of me/my child to the designated Recipient. By accepting the records pursuant to this Authorization, the Recipient acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Ms. Gray's release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

_____

Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

____ Entire Record _____ Evaluation Reports

_____ Billing Records _____ Consultation Notes

_____ Psychotherapy Notes ____ Other_____

Description of the purpose of the use and/or disclosure: _____

_____

The individually identifiable health information described herein shall be released to:

[INSERT NAME AND ADDRESS OF DESIGNATED RECIPIENT]

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I further understand that I may revoke this authorization at any time by notifying Ginger Gray, LCSW in writing at Abiding Hope Christian Counseling, 19115 FM 2252, Suite 12, San Antonio, TX 78266. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Client or Client's Representative Date

_____

Printed Name of Client or Client's Representative

_____ _____

Relationship to Client or Legal Authority (attach supporting documentation)