Client / Therapist ____ / ____

Abiding Hope Christian Counseling, Ltd.
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NEW MINOR CLIENT INTAKE FORM
(Please Print and fill out before first session)

TODAY'S DATE: ________________ HOME PHONE: ______________

NAME: ____CELL: ______________

ADDRESS:
____D.O.B.______________

CITY, STATE, ZIP: ________________________________STATUS: S M D W

E-Mail address: ____

REFERRED BY: __________________________________

School if Student _________________________________ Grade: ___________

Parent/Guardian Name: _____________________________________

Relationship to Client: _____________________________________

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

Psychiatrist Name: ____ Phone:
____

Does your child have any medical or mental health diagnoses?
____
____

Has your child been in counseling before? Yes / No

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

____

____

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:

____

____

____

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:

____

____

____

Was your child adopted? Yes/No

Please describe the circumstances of the adoption:

____

____

____

Siblings (age, sex, and relationship):

____
____
____

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:

____
____
____

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

____
____
____

Has your child has 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?

____
____
____

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

____
____
____

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

____
____
____

Please describe discipline in your home and who enforces it.

____
____
____

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

____
____
____

What churches or denominations has the family primarily attended?

____
____
____

Are you comfortable incorporating your faith into the counseling process?

____
____

Are you comfortable with prayer in counseling sessions?

____