



Abiding Hope

Christian Counseling

Abiding Hope Christian Counseling, LTD.

Antony Ashby, MA, LPC-Intern

Supervised by Alan Lobaugh, LPC-S

19115 FM 2252 Ste. 12

San Antonio, TX 78266

www.abidinghopecc.com

PLEASE PRINT

TODAY'S DATE: _____

HOME PHONE: _____

NAME: _____ CELL: _____

ADDRESS: _____ D.O.B. _____

CITY, STATE, ZIP: _____ STATUS: S M D W

E-Mail address: _____

INSURED'S NAME: _____ INSURED'S DOB : _____

INSURANCE COMPANY _____

INS. I D # _____ INS. GROUP # _____

REFERRED BY: _____

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:

- | | |
|---|-----------------|
| <input type="checkbox"/> Anxiety | How long? _____ |
| <input type="checkbox"/> Depressed Mood | How long? _____ |
| <input type="checkbox"/> Low energy level | How long? _____ |
| <input type="checkbox"/> Racing thoughts | How long? _____ |
| <input type="checkbox"/> Poor concentration | How long? _____ |
| <input type="checkbox"/> Indecisiveness | How long? _____ |
| <input type="checkbox"/> Change in sleeping | How long? _____ |
| <input type="checkbox"/> Change in appetite | How long? _____ |
| <input type="checkbox"/> Angry outbursts | How long? _____ |
| <input type="checkbox"/> Crying spells | How long? _____ |
| <input type="checkbox"/> Lack of motivation | How long? _____ |
| <input type="checkbox"/> Weight change | How long? _____ |
| <input type="checkbox"/> Feeling others are against him/her | How long? _____ |
| <input type="checkbox"/> Excessive guilt | How long? _____ |
| <input type="checkbox"/> Isolation | How long? _____ |
| <input type="checkbox"/> Mood swings | How long? _____ |
| <input type="checkbox"/> Feelings of hopelessness | How long? _____ |
| <input type="checkbox"/> Low self-esteem | How long? _____ |
| <input type="checkbox"/> Difficulty with memory | How long? _____ |
| <input type="checkbox"/> Thoughts/plans of suicide | How long? _____ |
| <input type="checkbox"/> Self-harm | How long? _____ |
| <input type="checkbox"/> Thoughts/plans to hurt others | How long? _____ |
| <input type="checkbox"/> Alcohol use | How long? _____ |
| <input type="checkbox"/> 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?
