Restoration Counseling

Restoration Counseling, LLC.
CHILD INTAKE FORM

(Form to be completed by parent, legal guardian, or custodial parent of child)

Date:_____

I. Child Information

Child Personal Information

Last Name: _____ First Name:_____ Middle Name:_____

What is the child's preferred name? _____
Birth date:_____

Does the child have siblings? __Yes __No If yes, how many? _____

Please provide the following information about the child's siblings (if any):

Name(s): _____ Date of Birth: – Male – Female

_____ Date of Birth: – Male – Female

_____ Date of Birth: – Male – Female

With whom does the child currently reside?_____

What is the name of the child's school? _____

In what grade is the child currently registered? _____

Please provide a brief description of the child's extracurricular activities and interests:

_____

_____

Child Medical History

How would you rate your child's current physical health? □ Excellent □ Good □ Fair □ Poor

Is your child currently complaining of any physical problems (e.g. headaches, stomach aches)?

□Yes □No If yes, please explain:

_____

Has your child ever been hospitalized for medical reasons? □Yes □No
If yes, please provide the following information:

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Please list your child's chronic medical conditions or disabilities, if any:

_____

Please list your child's learning disabilities, if any:

_____

Please list the medications that your child is currently taking, if any:

MEDICATION(S) Over-the-counter or prescription	DOSAGE

Child Mental Health History

Has your child previously been treated by, consulted with, or received counseling/therapy from a mental health professional? □Yes □No If yes, when? _____

Is your child currently under the care of a mental health professional? □Yes □No

If yes, what is that professional's name?_____

What prompted the child's previous visitation to a mental health professional?

_____

Has the child ever been diagnosed with or treated for any type of mental illness? □Yes □No

If yes, what was the diagnosis? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness?

□Yes □No If yes, what was the diagnosis? _____

Reasons for Seeking Help

What concerns about the child have brought you to seek our counseling services?

_____

_____

Where are these concerns causing the most problems for YOU? Please check all that apply:

□Home □Work □Marriage □Other: _____

Where are these concerns causing the most problems for your CHILD? Please check all that apply:

□Home □School □Friends □Other: _____

When did the present concerns begin to be a problem for your child?

_____

_____

Have others (besides family members) identified concerns regarding your child? □Yes □No

If yes, please briefly describe the nature of these concerns:

_____

Please indicate which of the following problems the child experiences. Check all that apply:

□Crying spells

□Excessive fears or anxieties

□Difficulty being away from specific family members

□Hearing voices

□Getting into trouble at school/play

□Temper tantrums

□Difficulty falling asleep/inability to sleep at night

□Decreased/increased appetite

□Loss of interest in usual activities family members

□Hyperactivity

□Bullying/picking fights

□Refusal to respond to authority

□Nightmares

□Obsessions/compulsion with specific activities

□Lack of motivation

□Lack of self-confidence

□Difficulty making or keeping friends

□Other: _____

II. Parent Information

Parent/ Guardian Personal Information

Last Name: _____ First Name:_____ Middle Name:_____

What is your preferred name? _____

Address: _____ Apartment #_____
City:_____ State:_____
Zip:_____

Phone (Day#): _____ (Evening #):_____ (Cell #):_____

Pager:_____ E-mail address:_____

May we leave a message on your telephone? □Yes □No If yes, on which number(s)?_____

May we mail counseling information to your home? □Yes □No

May we send counseling information to your e-mail address? □Yes □No

What is the highest level of education that you have achieved?
_____

Do you work? □Yes □No If yes, what is your occupation?_____

Parent/ Guardian Relationship Information

What is your current marital status? □Single □Married □Separated □Divorced □Widowed

Have you ever been married? □Yes □No If yes, how many marriages have you had? _____

Have you ever been divorced? □Yes □No If yes, when? _____

Have you ever been separated? □Yes □No If yes, when? _____

If you are separated or divorced:

Do you have at least partial custody of your child(ren)? □Yes □No

If yes, what percentage of the time does your child(ren) reside with you? _____

With whom does your child(ren) reside when they are not with you?_____

Do you have legal authority to seek counseling for your child? □Yes □No

Are you legally required to have consent from another custodial parent prior to seeking counseling for your child? □Yes □No

****NOTE**: If you are not required to obtain the consent of another custodial parent, you still must present a copy of the divorce decree to Restoration Counseling, LLC. before counseling can begin.

Parent/ Guardian Personal Spiritual Information

Do you believe in God? □Yes □No

Are you a Christian? □Yes □No

If not, how would you describe your religious beliefs? _____

Please describe the significance of faith in your life? _____

How much influence does your religion/ faith have on your day-to-day activity?

- A lot
- A moderate amount
- A little
- None

Has your faith changed recently? □Yes □No If yes, describe how:_____

_____

If you are married, what is the religious background and belief of your spouse?_____

_____

Do you and your spouse agree on religious issues? □Yes □No

If no, describe your differences:_____

_____

Are you a member of a church? □Yes □No If yes, which one? _____

Emergency Contact Information

Who should Crucible Counseling Center, Inc. contact in the event of an emergency involving your child? _____

What is his/her relationship to the child? _____

What is his/her telephone number? _____

Counseling Information

What do you hope to gain from bringing your child to receive counseling?

_____

_____

How did you hear about Restoration Counseling? □Friend □Church □Pastor □Other: _____

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

Restoration Counseling

Restoration Counseling, LLC.
CONSENT FOR COUNSELING MINORS

Name of
Parent/Guardian_____

Name of Minor Recipient of Counseling Services ("Minor" or "Child")_____

Minor's Date of Birth _____

Are you the parent of this Child? □Yes □No

Are you currently married to the Child's other parent? □Yes □No

Are you divorced? □Yes □No If yes, are you the custodial parent of the Child? □Yes □No
If yes, please provide Restoration Counseling, LLC., with a copy of the divorce decree.

Are you the legal guardian of the Child? □Yes □No If yes, please provide Restoration Counseling, LLC , with a copy of the guardianship form.

* * * *

By signature below, I certify that I authorize and give permission to Restoration Counseling, LLC, to provide counseling services to my child.

I understand that counseling services may include individual or family psychotherapy, counseling, and testing. I also understand such counseling services may include consultations with other members of the staff of Restoration Counseling and also may include referrals to other appropriate professional, county, or state agencies, where necessary.

_____

Signature of Parent/Guardian/Custodial Parent Date

_____

Signature of Parent/Guardian/ Custodial Parent Date

Street Address

_____

City/State/Zip

_____

Home Phone _____ Work Phone _____

Emergency Contact (Other than yourself):

Name _____ Phone _____

_____

Signature of Witness/Title **Date**