# *River of Life Christian Counseling*
# Intake Form - Child

TODAY'S DATE _____

## CLIENT INFORMATION

CHILD'S NAME _____
Last First Middle

DATE OF BIRTH_____ _____MALE _____FEMALE

SCHOOLCHILD ATTENDS_____ GRADE_____

HOW WAS YOU CHILD REFERRED TO OUR OFFICE?_____

_____

MOTHER'S NAME _____
Last First Middle

DATE OF BIRTH _____

FATHER'S NAME _____
Last First Middle

DATE OF BIRTH _____

THIS CHILD **primarily** LIVES WITH: (please circle)

| | | | |
|---|---|---|---|
| Mother & Father | Mother only | Father only | Mother & Stepfather |
| Father & Stepmother | Mother & other | Father & other | 50/50 custody |

Other Arrangement (Please identify) _____

ADDRESS AT WHICH CHILD RESIDES:

ADDRESS _____
Street City State Zip

(If 50/50 living arrangement, enter Mother's information here and Father's at # 1 below, OR, **if there is 50/50 custody but the child has a primary residence**, enter the primary residence information here and state whether this is:
Mother's..... or Father's.....residence. (please circle.)

PHONE at this address: _____

IF CHILD LIVES IN THE SAME HOUSEHOLD WITH BOTH PARENTS, PLEASE SKIP TO *** BELOW, thanks.
Otherwise, PLEASE RESPOND TO NUMBERS 1-4 WHERE APPLICABLE:

1. IN THE CASE OF 50/50 LIVING ARRANGEMENT, you have entered the mother's information above, please enter the father's address and home phone number here, and then skip to *** below:

FATHER'S ADDRESS:

ADDRESS _____
Street City State Zip

PHONE at this address _____

2. IF BIOLOGICAL PARENTS ARE NOT LIVING TOGETHER, WHO HAS PRIMARY CUSTODY? _____

3. IF CHILD PRIMARILY LIVES WITH MOTHER & STEPFATHER OR OTHER, please enter the stepfather's/other's name here: _____

4. IF CHILD PRIMARILY LIVES WITH FATHER & STEPMOTHER OR OTHER, please enter the stepmother's/other's name here: _____

***PERSON TO CONTACT IN AN EMERGENCY (name, relationship, address, phone number):

_____

_____

## INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL? _____ DATE OF BIRTH: _____

ADDRESS (if different): _____

PHONE NUMBER: _____

OCCUPATION: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE CLAIMS ADDRESS: _____

SUBSCRIBER'S NAME: _____SUBSCRIBER'S S.S. no., _____

BIRTHDATE: _____GROUP no.: _____ POLICY no. _____

CLIENT'S RELATIONSHIP TO SUBSCIBER: (please check one) :

_____SELF _____SPOUSE _____CHILD _____ OTHER

## ADDITIONAL CLIENT INFORMATION:

DOES YOUR CHILD ATTEND CHURCH REGULARLY? YES_____ NO _____

IF YES, WHERE? _____

_____

_____

BRIEFLY DESCRIBE YOURCHILD'S FAITH EXPERIENCE? _____

_____

_____

_____

PLEASE LIST THE NAMES, BIRTH DATES, GENDER AND RELATIONSHIP OF INDIVIDUALS IN CHILD'S IMMEDIATE FAMILY, (Please indication whether they live at home):

| NAME | BIRTH DATE | GENDER | RELATIONSHIP | AT HOME? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

NATURE OF PROBLEM FOR WHICH YOUR CHILD IS SEEKING COUNSELING (BRIEFLY DESCRIBE) _____

_____

_____

_____

_____

_____

HAS YOU CHILD HAD ANY PRIOR COUNSELING? YES_____ NO _____ IF YES, WHEN, WHERE, WITH WHOM AND FOR WHAT PURPOSE? _____

_____

_____

_____

_____

_____

DOES YOU CHILD HAVEANY CURRENT SUICIDAL THOUGHTS, FEELINGS OR ACTIONS? YES_____NO _____

IF YES, PLEASE EXPLAIN _____

_____

_____

DOES YOUR CHILD HAVE ANY CURRENT HOMICIDAL OR ASSAULTIVE THOUGHTS OR FEELINGS, OR ANGER-CONTROL PROBLEMS? YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

HAS YOU CHILD HAD A HISTORY OF SUCIDIAL/SELF-HARM AND/OR HOMICIDAL BEHAVIOR IN THE PAST? YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

HAS YOU CHILD HAD ANY PAST HOSPITALIZATIONS.? YES_____ NO _____

IF YES, PLEASE EXPLAIN (dates, place, reason)_____

_____

_____

_____

_____

IS YOUR CHILD EXPERIENCYING ANY CURRENT LIFE STRESSORS ? (school, family, illness, etc.)

YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

DOES YOUR CHILD HAVE ANY FAMILY HISTORY OF MENTAL HEALTH ISSUES?

YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

PLEASE LIST YOUR CHILD'S PEDIATRICIAN OR FAMILY DOCTOR:

NAME _____

ADDRESS_____PHONE_____

WHEN WAS YOUR CHILD'S LAST MEDICAL EXAM?_____

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS?_____

_____

_____

_____

_____

DOES YOU CHILD HAVE ANY PROBLEMS WITH: (please check all that apply)

_____EATING ____SLEEPING _____PAIN _____RECENT WEIGHT CHANGES

IS YOUR CHILD PRESENTLY TAKING ANY MEDICATIONS (If yes please list)_____

_____

_____

_____

# Informed Consent for Treatment

Counseling is a joint effort involving, both, yourself, and/or your child and your counselor. The success or failure of counseling is a function of the efforts of both the counselor and the client(s) seeking the service. In general, the benefits of counseling may include increased insight, improvement in self-esteem, improvement in interpersonal relationships, relief of symptoms including decreased anxiety and/or depression, and improvement in your ability to maintain your daily level of functioning. (Specific problem areas/needs and counseling goals will be addressed with you or your child's counselor.)

It is possible that counseling may provide a temporary increase in you or your child's symptoms or stress level due to the need to focus on the problem areas.

Diagnostic assessment, with or without formal testing, is an important aspect of your or your child's treatment to aid in increasing knowledge of your or your child's personality and/or intellectual functioning as well as an aid in your or your child's progress in counseling.

From time to time, your counselor may consult with other counselors of River of Life Christian Counseling regarding a clinical matter. All counselors of River of Life Christian Counseling are bound by confidentiality. In the event that additional information needs to be obtained or your counseling services discussed with a third party, you will be asked to sign a release of information.
By signing this informed consent for treatment, you agree you have received River of Life Christian Counseling Handbook which, among other things, details information concerning your privacy rights and agree with the terms stated therein.

I understand that I am financially responsible for all charges incurred. Payment (or co-payment for client's with applicable insurance) is due at time of each visit. I am aware that River of Life Christian Counseling requires a 24-hour cancellation notice and I will be billed 50% of the session rate if I do not keep an appointment and did not give this cancellation notice.

I hereby authorize the staff of River of Life Christian Counseling to use any or all procedures and treatments customarily employed in counseling, which may or may not include talk therapy, testing, biblio-therapy, prayer, and Scriptural instruction.

_____ Initials — I consent to receive mental health services.

_____ Initials — I consent for my child, _____, to receive mental health services.

_____ Initials — As Guardian, I consent for, _____, to receive mental health services

_____

Signature of Client/Parent/Guardian — Date

_____

Signature of Counselor — Date