

*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 YOUR 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 there is a 50/50 living arrangement, enter Mother's information above 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 above and write on the line provided whether this is the mother's or father's residence. \_\_\_\_\_)

PHONE at this address: \_\_\_\_\_

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

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

EMERGENCY CONTACT (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 SUBSCRIBER: (please check one):

\_\_\_\_\_ SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_ OTHER

**ADDITIONAL CLIENT INFORMATION:**

DOES YOUR CHILD ATTEND CHURCH REGULARLY? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHERE? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

BRIEFLY DESCRIBE YOUR CHILD'S FAITH EXPERIENCE? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

<u>NAME</u>	<u>BIRTH DATE</u>	<u>GENDER</u>	<u>RELATIONSHIP</u>	<u>AT HOME?</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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HAS YOUR CHILD HAD ANY PRIOR COUNSELING? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, WHEN, WHERE, WITH WHOM AND FOR WHAT PURPOSE? \_\_\_\_\_

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DOES YOUR CHILD HAVE ANY CURRENT SUICIDAL THOUGHTS, FEELINGS OR ACTIONS? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, PLEASE EXPLAIN \_\_\_\_\_

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DOES YOUR CHILD HAVE ANY CURRENT HOMICIDAL OR ASSAULTIVE THOUGHTS OR FEELINGS, OR ANGER-CONTROL PROBLEMS? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, PLEASE EXPLAIN \_\_\_\_\_

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HAS YOUR CHILD HAD A HISTORY OF SUICIDAL/SELF-HARM AND/OR HOMICIDAL BEHAVIOR IN THE PAST? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, PLEASE EXPLAIN \_\_\_\_\_

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HAS YOUR CHILD HAD ANY PAST HOSPITALIZATIONS? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE EXPLAIN (dates, place, reason) \_\_\_\_\_

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

YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE EXPLAIN \_\_\_\_\_

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

YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, PLEASE EXPLAIN \_\_\_\_\_

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PLEASE LIST YOUR CHILD'S PEDIATRICIAN/FAMILY DOCTOR:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

WHEN WAS YOUR CHILD'S LAST MEDICAL EXAM? \_\_\_\_\_

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS? \_\_\_\_\_

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DOES YOUR 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 you, your child, and the 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 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 child's treatment to aid in increasing knowledge of your child's personality and/or intellectual functioning as well as an aid in your child's progress in counseling.

From time to time, your child's 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 child's counseling services discussed with a third party, you, as the parent or legal guardian, will be asked to sign a release of information.

By signing this informed consent for treatment, you agree you have received the 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.

\_\_\_\_\_ I consent for my child, \_\_\_\_\_, to receive mental health services.

Initials

\_\_\_\_\_ As Guardian, I consent for, \_\_\_\_\_, to receive mental health services

Initials

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Signature of Parent/Guardian

Date

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Signature of Counselor

Date