R & R Restoration Ministry
Child and Teen Intake Form

Instructions: Please complete the survey as accurately as possible, including any information that you feel could benefit the counseling process relevant to your child/teen. All information contained in this survey is confidential except as prohibited by state/federal law regarding major criminal offenses and child, elderly, or disabled persons abuse.

CHILD/TEEN PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____
(Primary Residence) Mailing Address City / State / Zip Code

PARENT OR GUARDIAN PERSONAL INFORMATION

Name: _____ Date: _____

Address (If different from the child/teen):

_____
Mailing Address City / State / Zip Code

Telephone: (cell) _____ (work) _____

Email address: _____

CHILD/TEEN FAMILY STATUS

Age:_____ Grade in School:_____ School Name:_____

Parent's Marital Status:
_____ Married _____ Separated _____Divorced _____ Remarried

Siblings (You do not need to include child's name):

Currently Living in the Home:
1) _____
gender / age
2) _____
gender / age
3) _____
gender / age
4) _____
gender / age

Not Living in the Home:
1) _____
gender / age
2) _____
gender / age
3) _____
gender / age
4) _____
gender / age

Where does the child/teen fall in the birth order? _____

SPIRITUAL HISTORY

Note: The counseling provided will be conducted from a faith-based perspective. While the counselee does not have to be of the Christian faith they understand that issues of faith will be an important component of the counseling process.

Does your child/teen attend church on a regular basis? Yes _____ No _____

Name of church or denomination. _____

PRESENTING PROBLEMS/REASON FOR SEEKING COUNSELING

What problem(s) is your child/teen experiencing?

_____ Anxiety / Panic Attacks
_____ Depression / Sadness
_____ Poor impulse control
_____ Poor school performance
_____ Poor coping skills
_____ Arguing / fighting with family
_____ Guilt / Shame
_____ Substance abuse
_____ Change in eating habits
_____ Irrational or exaggerated fears
_____ Coping with parents separation/divorce
_____ Tries to control everything/everyone
_____ Poor concentration
_____ Inability to control anger
_____ Arguing / fighting with peers
_____ Rebellion
_____ Pornography
_____ Change in sleeping patters
_____ Other (please specify) _____
_____

What specific issue(s) are you hoping will be addressed through counseling?
Note: The counseling provided will be conducted from a faith-based perspective.

_____
_____
_____
_____

Is your child/teen currently being treated by a physician or on medication(s) to address ADHD, depression or other mental/emotional problems?

_____ No _____ Yes (please specify medication and therapeutic purpose)

_____
_____

PERSONAL INVENTORY

How would your child/teen describe themselves in one or two word phrases:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

ADDITIONAL INFORMATION

Please describe any additional information that you feel is important to the counseling process. _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

In case of an emergency contact:

Name: _____ Relationship: _____

Address: _____

Mailing Address City / State / Zip Code

Telephone:(home) _____ (cell) _____

PAYMENT INFORMATION

Payment for counseling services is due upon receipt of services. The standard fee is $85.00 per session unless prior arrangements have been made. Cancellations not made 24 hours in advance may result in a $30.00 cancellation fee.

_____ _____

Signature Printed Name

_____

Date