



INITIAL PAPERWORK PACKET – MINOR (AGES 6-13)

INSTRUCTIONS FOR YOUR FIRST APPOINTMENT:

1. Print this information packet and complete all aspects before your appointment date. Please bring the completed packet with you to your first appointment. For children from divorced parents, the initials and signature of the child's non-custodial parent are also required unless parental rights have been terminated.
2. Please use blue or black ink when completing these forms. Also, please provide detailed answers to each question on the form.
3. If you are taking any prescription medication(s), please do not alter your dose near your appointment date. If possible, allow two (2) weeks to adjust to any medication before your appointment date.
4. Office hours vary for appointments. Counseling appointments will require approximately one hour in the office. Bathroom facilities are available and childcare is not provided (though a TV/VCR/DVD & videos are available in the Brodheadsville office).

DATE: _____

PERSONAL DATA INVENTORY - Minor

Biological Parent Information:

Parents' Names: _____ Age Male: _____ Age Female: _____

Custodial Parent Address: _____ City/State: _____ Zip: _____

Please provide at least two (2) phone numbers:

Home: _____ Cell: _____ Work: _____

E-mail Address: _____

Mother Occupation / Employer: _____ Father Occupation / Employer _____

Mother Education (last year completed): _____ Father Education (last year completed): _____

Parents' Marital Status:

- Married
- Separated
- Divorced
- Widowed

Child primarily resides with (check all that apply – also, please print the name of the person with whom the child resides):

- Mother
- Father
- Step-parent _____
- Parent's boy/girlfriend _____
- Grandfather _____
- Grandmother _____
- Uncle _____
- Aunt _____
- Adopted parents

Other: _____

Child in Counseling:

Name: _____ Age: _____

Nickname: _____

Grade: _____ School: _____ Guidance Counselor: _____

Is your child coming to counseling voluntarily? Yes () No () Uncertain ()

Has your child ever lived outside the home? Yes () No () When? _____

Please Explain: _____

Brothers / Sisters	Age	Gender	Living Yes/No	Married Yes/No	PM/A*

* Check this column if child is by previous marriage or adoption.

HEALTH INFORMATION

State of child's health: Very Good () Good () Average () Declining () Other: _____

Weight Changes recently: Lost _____ lbs. Gained _____ lbs.

Date of last medical examination: _____ Results: _____

Is the child presently taking any medication? Yes () No () Prescribing Doctor(s): _____

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED FOR...	DATE PRESCRIBED

** Use another page if necessary*

Has the child used drugs for other than medical purposes? Yes () No () What/When? _____

Has the child drunk alcoholic beverages? Yes () No () How often / much? _____

Has the child had counseling, psychotherapy, or seen a psychiatrist before? Yes () No ()

Age	Duration	Counselor / Center	Issue/Topics/Diagnosis	Evaluation/Result

** Use back of this page if necessary or if you have seen more than three counselors*

Approximately how many hours of sleep does the child average each night? _____

When does your child normally: go to bed? _____ fall asleep? _____ wake up? _____ get out of bed? _____

What does your child normally do between going to bed and falling asleep? _____

Describe any recent changes in sleep habits: _____

Has your child ever complained of or exhibited the following:

Felt people were watching him / her or out to get him / her?	Yes	No	Afraid of being in a car, bathroom, other places, school, etc? _____	Yes	No
People's faces ever seem distorted?	Yes	No	Hearing exceptionally good?	Yes	No
Difficulty distinguishing faces?	Yes	No	Bedwetting or daytime wetting?	Yes	No
Colors ever seem too bright?	Yes	No	Bruises that cannot be explained?	Yes	No
Colors ever seem too dull?	Yes	No	Sexually provocative behaviors?	Yes	No
Unable to judge distance?	Yes	No	Touching their private parts frequently?	Yes	No
Audio (hearing things) or visual (seeing things) hallucinations?	Yes	No			

PERSONAL INFORMATION

Check any of the following words which best describe **your child** *at this time*.

- | | | | | |
|-------------------------------------|-------------------------------------|-----------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Impatient | <input type="checkbox"/> Calm | <input type="checkbox"/> Outgoing | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Serious | <input type="checkbox"/> Likable | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Moody | <input type="checkbox"/> Easy-going | <input type="checkbox"/> Leader | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Persistent | <input type="checkbox"/> Often Blue | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Follower | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Excitable | <input type="checkbox"/> Self-Confident | <input type="checkbox"/> Imaginative | <input type="checkbox"/> Pessimistic |

Check any of the following struggles or difficulties that **your child** is experiencing *at this time*.

- | | | | |
|------------------------------------------|-----------------------------------------------|---------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Abuse (present) | <input type="checkbox"/> Communication | <input type="checkbox"/> Lifestyle change | <input type="checkbox"/> Self-Injury |
| <input type="checkbox"/> Abuse (past) | <input type="checkbox"/> Conflict Resolution | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Step-Family Issues |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Depression | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Suicidal Thinking |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Eating / Food Issues | <input type="checkbox"/> Obsessions / Compulsions | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Envy | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Fear | <input type="checkbox"/> Peer Issues | <input type="checkbox"/> Work Issues |
| <input type="checkbox"/> Bad Memories | <input type="checkbox"/> Financial Management | <input type="checkbox"/> People Pleasing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bitterness | <input type="checkbox"/> Grief | <input type="checkbox"/> Pornography | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Guilt | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Co-Dependency | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Purpose | <input type="checkbox"/> Other _____ |

Please ask your child to finish these statements:

What really hurts me is _____

What I wish I could change about myself is _____

My childhood was _____

My father is/was _____

My mother is/was _____

My biggest regret is _____

For refuge/rest I turn to _____

To be happy I need _____

I would do anything for _____

If your child was reared by anyone other than his / her parents, please briefly explain: _____

How many older siblings does your child have? Brothers _____ Sisters _____

How many younger siblings does your child have? Brothers _____ Sisters _____

Any major changes in the family during the last year (i.e. death, sickness, move, divorce) Yes No

Explain _____

PARENTAL INFORMATION

Biological Mother (If the mother is absent, you may describe the child's primary female role model – ie. step-mother, grandmother, etc.): **If other female role-model, please state role:** _____

Check any of the following words which best describe **the child's mother**.

- | | | | | |
|----------------|----------------|--------------------|-----------------|-----------------|
| ___ Active | ___ Impatient | ___ Calm | ___ Outgoing | ___ Lonely |
| ___ Ambitious | ___ Impulsive | ___ Serious | ___ Likable | ___ Shy |
| ___ Angry | ___ Moody | ___ Easy-going | ___ Leader | ___ Sensitive |
| ___ Persistent | ___ Often Blue | ___ Self-Conscious | ___ Follower | ___ Optimistic |
| ___ Nervous | ___ Excitable | ___ Self-Confident | ___ Imaginative | ___ Pessimistic |

Has the child's mother ever been diagnosed with a mental health disorder? Yes () No ()

What/When? _____ Taking medication? Yes () No ()

Does the mother drink alcoholic beverages or use/abuse drugs? Yes () No () In Past () When? _____ How often / much? _____

Approximately how many hours of sleep does the mother average each night? _____

Please describe methods of discipline used by the mother. _____

Please describe the relationship between the child and biological mother. _____

Biological Father (If the father is absent, you may describe the child's primary male role model – ie. step-father, grandfather, etc.): **If other male role-model, please state role:** _____

Check any of the following words which best describe **the child's father**.

- | | | | | |
|----------------|----------------|--------------------|-----------------|-----------------|
| ___ Active | ___ Impatient | ___ Calm | ___ Outgoing | ___ Lonely |
| ___ Ambitious | ___ Impulsive | ___ Serious | ___ Likable | ___ Shy |
| ___ Angry | ___ Moody | ___ Easy-going | ___ Leader | ___ Sensitive |
| ___ Persistent | ___ Often Blue | ___ Self-conscious | ___ Follower | ___ Optimistic |
| ___ Nervous | ___ Excitable | ___ Self-Confident | ___ Imaginative | ___ Pessimistic |

Has the child's father ever been diagnosed with a mental health disorder? Yes () No ()

What/When? _____ Taking medication? Yes () No ()

Does the father drink alcoholic beverages or use/abuse drugs? Yes () No () In Past () When? _____ How often / much? _____

Approximately how many hours of sleep does the father average each night? _____

Please describe methods of discipline used by the father: _____

Please describe the relationship between the child and biological father: _____

SPIRITUAL / RELIGIOUS INFORMATION

Primary Caregiver / Parent:

DO YOU CONSIDER YOURSELF A RELIGIOUS PERSON? Yes () No ()

Do you attend church? Yes () No () Denominational Preference: _____

If yes, Church Name: _____ Church Attendance/Activities: _____ times / month

Please list any ministry involvement: _____

DO YOU BELIEVE IN GOD? Yes () No () Not Sure ()

DO YOU PRAY TO GOD? Never () Occasionally () Often ()

What do you pray about? _____

ARE YOU SAVED? Yes () No () Uncertain ()

Do you read the Bible? Never () Occasionally () Often ()

Do you have personal devotions? Never () Occasionally () Often ()

Please note any recent changes in your spiritual life: _____

Please complete the following in one or two sentences:

1. Please describe the reasons for coming to counseling. _____

2. Other than counseling, what help are you seeking? _____

3. What are your expectations in coming here? _____

4. What, if any are your concerns about coming to counseling? _____

5. Please list and describe key *positive* peer relationships in your child's life. _____

6. Please list and describe key *negative* peer relationships in your child's life. _____

7. Is there any other information we should know? _____

FOUNDATIONS CHRISTIAN COUNSELING SERVICES, Inc.

Instructions for Policy Review: *Please read each of the policies on the following three (3) pages. After reading each policy please place your initials in the space provided to indicate your understanding and agreement with the stated policy. For children of divorce, the initials and signature of the child's non-custodial parent are also required unless parental rights have been terminated. If you have any questions please direct them to your counselor prior to your initial meeting. If for any reason you are unable to sign these forms, counseling services will not be available to you.*

FINANCIAL POLICY

Foundations is a non-profit organization which provides counseling services on a fee for service basis. Therefore, it is the responsibility of each client to cover the costs for their counseling. Our regular fee is \$65.00 per 55-minute session; however the fees for counseling services are reduced for members and regular attendees of partnering churches, and for those who qualify for the Foundations Fund, a scholarship program helping low-income families afford biblical counseling. Fees for counseling services are expected at each session. There is a \$25 charge for returned checks.

** Initial here if you understand and agree with this Financial Policy: _____

APPOINTMENT CANCELLATION POLICY

We require a 24 hour notice if you wish to cancel or are unable to keep an appointment (48 hours preferred). Email is not an acceptable form of contact. If you fail to give us a 24 hour notice you may be expected to pay a missed appointment fee of \$50.00 before another appointment may be scheduled. Appointments cancelled due to inclement weather or emergency situations as understood by the counselor are exempt from the missed appointment fee.

Clients are encouraged to arrive promptly for their counseling session. If a client arrives late, the counseling session will end at the regularly scheduled time and the client will be charged at the full rate. The therapist reserves the right to cancel the session if the client is at least 15 minutes late.

If the therapist cancels the appointment for reasons unrelated to the client, the client will be notified as soon as the conflict has been determined. If the therapist is late for the session, the client can expect a full, 55-minute session. The client will not be penalized for any scheduling conflicts or delays by the therapist.

** Initial here if you understand and agree with this Cancellation Policy: _____

CONFIDENTIALITY CLAUSE

The privacy and confidentiality of our conversations and records are a privilege of yours and are protected by our ethical principles in all but a few circumstances. Those exceptions are limited to the following: 1) known or suspected child or elderly abuse or neglect; 2) court order; 3) active suicidal ideations or intent to harm another; and, 4) counseling that is mandated by a legal authority. If counseling was mandated by a legal authority, it is assumed by your signature that you agree that your counselor may give/receive updates and opinions and share records for the purpose of professional continuity.

Your counselor reserves the right to consult with other counselors at Foundations for the purpose of providing the highest level of care. As a para-church ministry, Foundations would prefer to work together with the church where you hold membership for the purpose of cooperative pastoral care. A signed, separate release form will be necessary.

** Initial here if you understand and agree with this Confidentiality Clause: _____

PHILOSOPHY OF CARE

We are committed to providing professional, biblically-based counseling to all whom we serve, regardless of sex, race, religion, or sexual preference. We believe that an individual's emotions, thoughts, behaviors, and interactions are *caused* by motives that stem directly from the heart. Though the cause of most behaviors come from the heart, we recognize that we are created as spirit and body. Therefore, we recognize that many actions and interactions are *influenced* by our body chemistry (hormones, deficiencies, adrenaline, etc.) as well as our situations and circumstances. It is our desire to provide counseling that is God-centered, Spirit-led, and Hope-focused to help clients find peace emotionally, relationally, and spiritually.

We believe that our past influences affect present realities and relationships. We will focus on the heart's responses to past and present influences and address some of the foundational issues of worth, love, and trust. In Biblical counseling, you can expect practical & Biblical directions on how to live by faith, renew the mind, manage emotions, resolve trauma of the past, and pursue peace in relationships.

When necessary we will work with your physician or psychiatrist to ensure you receive the appropriate medical care in conjunction with the counseling services you receive.

* * Initial here if you understand and agree with this Philosophy of Care: _____

WAIVER OF LIABILITY

In seeking counseling from *Foundations Christian Counseling Services*, you must acknowledge your understanding of the following conditions and further release *Foundations Christian Counseling Services*, its agents, affiliates, counselors, employees, Board of Directors, and all ministry team leadership, from any legal liability, claim, or litigation arising from your participation in this voluntary program:

1. All counseling will be provided by ordained ministers, Masters-level Biblical counselors, or an enrolled student at a Biblical counseling post-graduate degree program;
2. All counseling is provided in accordance with the Biblical principles adhered to by *Foundations Christian Counseling Services* and are not necessarily provided in adherence to any local or national psychological or psychiatric association;
3. No representation has been made, either expressly or implied, that the biblical counseling, as conducted by the above mentioned counselors, is accepted as customary psychological and/or psychiatric therapy within the definitional terms utilized by those professions;
4. It is understood by the participant counselee(s) that all complaints and grievances will be heard by the Executive Director. If the goal of reconciliation cannot be achieved between the aforementioned parties, then the participant counselee(s) may elect to involve an agreed upon, trained pastor or *Peacemaker Ministries, Inc.*, at their expense, for the purpose of mediation or arbitration.

** Initial here if you understand and agree with this Waiver of Liability: _____

CONSENT TO COUNSEL

Having read and understood *Foundations Christian Counseling Services'* Financial Policy, Appointment Cancellation Policy, Confidentiality Clause, Waiver of Liability, and Philosophy of Care,

I, _____ (print parents' name(s)) grant permission for *Foundations Christian Counseling Services* to render counseling services to me and the names listed below (minors):

I also understand that *Foundations Christian Counseling Services* may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, failure to pay for services rendered, or for other issues agreed upon by the Board of Directors.

Please sign to indicate the following:

1. You have read the policies in this document;
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into counseling of your own will.

1. Parent Signature _____ Date: _____

2. Parent Signature (if applicable) _____ Date: _____

3. Client Signature (if applicable) _____ Date: _____

Counselor Signature _____ Date: _____