

Life Counseling Center

Confidential In-Take Form

2600 Marriottsville Road – Marriottsville MD 21104

lifecounselingcenter.org - 443-419-3884

Personal Data Inventory Minor

General Information (Person Receiving Counseling)

Name: _____ Today's Date: _____

Male Female Birth Date: _____ Age: _____ Grade: _____

Full Address: _____

Cell Phone: _____ School: _____

Is there any diagnosis or label (educationally, emotionally/socially or physically)? _____

Consent for Minors (To be filled out by parents)

Mother/Guardian Name: _____ Age: _____

Full Address: _____

Home Phone: _____ Cell Phone: _____ *please circle best number to reach you*

Occupation: _____ E-Mail: _____

Father/Guardian Name: _____ Age: _____

Full Address (if different from above) _____

Home Phone: _____ Cell Phone: _____ *please circle best number to reach you*

Occupation: _____ E-Mail: _____

Siblings names and ages:

I/we _____ give consent for our minor son/daughter _____
to receive counseling at Life Counseling Center.

Life Counseling Center Confidentiality Policy

Life Counseling Center believes confidentiality is a vital aspect of the counseling relationship. Counselors agree to carefully guard the information entrusted to us by our counsees to the fullest extent possible in order to ensure the integrity of the counseling process. However it is our responsibility to appropriately protect and warn. We are therefore unable to maintain confidentiality in any of the following areas.

- Any known or suspected child/elderly abuse or neglect.
- Suicidal intention or plans for suicide are disclosed.
- Terrorist plans or involvement.
- Homicidal intention.

In addition, there are certain circumstances where your counselor may need to discuss some of the content of a counseling session with others. These circumstances can include supervision, observation, oversight, and when others are involved in your counseling process.

Supervision is a normal part of counseling. In supervision, counselors share only what is necessary to receive support and direction from their supervisor.

Observation provides continual training and critique to help counselors grow in their abilities. You will never be observed without your permission and consent.

We believe the local church is an essential part of a person's continued growth. Because Life Counseling Center is a ministry of Chapelgate Presbyterian Church there may be times where pastoral oversight is fitting for members. If you do not attend Chapelgate we may suggest pastoral support from your local church if appropriate. Pastoral oversight will not be sought without your knowledge and consent.

Finally, in the case of marriage or family counseling confidentiality is limited. In most situations the confidentiality belongs to the relationship. Your counselor will appropriately work with you to determine the best way to proceed in these circumstances.

We do not provide services relating to testifying in court on behalf of the individuals we counsel. If your counseling subject requires testimony or representation in a court setting by a counselor, Life Counseling Center will not be able to accommodate your needs.

I understand and agree with this Confidentiality Statement:

Signature

Date

Note: Counseling of children and adolescents:

Our policy is that when a counselor meets with children and adolescents, to ask their parents or guardians to agree that most details of what their children or adolescents tell the counselor will be treated as confidential. However, parents or guardians do have the right to general information about how counseling is going. The counselor may also have to tell parents or guardians about information if their children or others are in any danger. If this situation comes up, the counselor will discuss it with the child or adolescent first before talking to the parents or guardians.

I understand _____

Counseling Agreement:

Thank you for your interest in counseling at the Life Counseling Center. We look forward to the opportunity to serve you. In order to clarify the counseling you will be receiving, please read the following agreement, sign and return the agreement before your first appointment.

- *Description of Counseling*

Your counseling will be biblical Christian counseling. You do not have to be a Christian to receive counsel. We are biblical counselors, not clinical mental health providers or therapists. All of our counselors are professionally trained and highly experienced to walk alongside you in your struggle and suffering.

- *Fees*

The fee for a 50-minute counseling session for minors age 17 and under is \$85 (\$95 for those 18 and over). In situations that require multiple counselors (i.e. family counseling, certain marriage counseling, or other group training events), fees will be adjusted to reflect the number of counselors working with you or your family. Payment is due at each visit before you meet with your counselor. We accept cash, checks and major credit cards. Sliding scale information is available upon request. Please discuss any special circumstances with the Director. There may be additional fees for other services or counseling needs such as phone or text conversations, e-mails, report writing, authorized consultations, preparation of records or treatment summaries, attending hearings or other services requested will incur additional fees.

- *Confidentiality*

The Life Counseling Center is very sensitive to the issue of confidentiality. To release counseling information without your consent would violate both biblical standards and commonly accepted codes of counseling ethics. Your case may be occasionally reviewed in a weekly supervision group, but every effort is made to safeguard the identity of each counselee and confidentiality is applied by the group as a whole.

- *Scheduling Appointments*

Initial appointments are set up with Pam Riley in the Life Counseling Center at 443-419-3884 or priley@chapelgate.org

- *Missed Appointments*

As a non-profit ministry, the Life Counseling Center must be a careful steward of our resources, including time.

Therefore, sessions must be cancelled 24 hours in advance or a cancellation fee of \$50/\$60 will be charged. A \$40 returned check fee will be charged if your check does not clear the bank when presented.

I have read and agree to the counseling agreement. _____

Personal Information

The information below will be given to your counselor before the start of your first appointment. There is no obligation to answer every question, however your answers help your counselor better care for you.

Religious Background

Church presently attending: _____

How often does the child attend church? _____ Are they actively involved? _____

Are you all members? Yes No Pastor's Name: _____

Does your pastor know of your decision to seek biblical counseling? Yes No

Do we have your permission to contact the pastor/youth pastor? Yes No

Personality Information & Present Situation

Circle any of the following words which best describe your child:

Active	Ambitious	Self-Confident	Persistent	Nervous	Hardworking	Impatient	
Impulsive	Moody	Often-Blue	Excitable	Imaginative	Calm	Serious	Shy
	Easy-Going	Good-Natured	Introvert	Likeable	Leader	Quiet	
Submissive	Self-Conscious	Lonely	Sensitive	Outgoing	Fearful	Anxious	Organized
	People Pleaser	Other _____					

Have they ever experienced...

- A parent's separation or divorce? Yes No
- A severe emotional upset, breakdown, loss or life-changing crisis? Yes No
- Suicidal ...thoughts? Yes No ...plans? Yes No ... attempts? Yes No
- Sexual/physical/mental/emotional abuse? Yes No

Check any of the following symptoms or problems that your child is currently or recently experienced:

- | | | |
|--|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Compulsive Behaviors | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Social Network Conflict | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Guilt/Shame | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Peer Conflict | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Fatigue/Lack of Energy | <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Drug Use |
| <input type="checkbox"/> Loss of Appetite/Overeating | <input type="checkbox"/> Gender Identity Issues | <input type="checkbox"/> Porn Use |
| <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Anger | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Aggressive Behavior | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Feeling Worthless | <input type="checkbox"/> Bad Dreams | <input type="checkbox"/> Abortion |

- | | | |
|---|---|---|
| <input type="checkbox"/> Unwanted Memories | <input type="checkbox"/> Promiscuity | <input type="checkbox"/> Sibling Conflict |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Fears | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Grade Decrease |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Loss of Control | <input type="checkbox"/> Impulsive Behavior |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Parenting Conflict | <input type="checkbox"/> Communication Issues |
| <input type="checkbox"/> Spiritual Problems | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Paranoia |
| | <input type="checkbox"/> Homicidal Thoughts | |

Please use an "X" on the scale below to indicate how distressing the problem(s) are today.



Have you or others noticed any changes in your child's personality (anger, mood swings, withdrawal), thinking and memory, or work habits? Yes No

Explain: _____

Briefly Answer The Following Questions:

1. What brings you to counseling? Please write a quick summary of your main concerns.

... how long have you had these concerns? _____

...was it your or your child's decision to pursue counseling? _____

2. What have you already done about these concerns? What have been the results?

3. Please describe any other significant events occurring presently.

4. What are your expectations and goals for counseling?

5. Has your child ever participated in counseling in the past? Yes No