LIFE COUNSELING CENTER MINISTRIES

Confidential Minor Intake 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?) _______

____

Name of person bringing the child in for counseling?

____

Relationship to child? ____

Consent for Minors (to be filled out by parents)

Mother/Guardian Name: ____________________________________ Age: ____________

Full Address: ____

Home Phone: _____________ Cell Phone: ____________ (*Circle best nr to reach you*)

Occupation: _________________________ E-mail: ________________________________

Father/Guardian Name: ____________________________________ Age: _____________

Full Address: (*if differs from above*)____

Home Phone: _____________ Cell Phone: ____________ (*Circle best nr to reach you*)

Occupation: _________________________ E-mail: ________________________________

Current marital status of child's parents: ☐ Married ☐ Separated ☐ Divorced

If separated, do you have a legal separation agreement? ☐ Yes ☐ No

Siblings (*names/ages*):

____

____

____

____

Consent must be signed by one of the child's parents or legal guardian. If parents are legally separated and have a separation agreement, both parents must sign consent to counsel.

By signing this consent form I (mother) _______________________________________ give consent for our minor son/daughter______________________________________ to receive counseling at Life Counseling Center Ministries.

By signing this consent form I (father) _______________________________________ give consent for our minor son/daughter_____________________________________ to receive counseling at Life Counseling Center Ministries.

By signing this consent form I (guardian) _______________________________________ give consent for our minor son/daughter_____________________________________ to receive counseling at Life Counseling Center Ministries.

Life Counseling Center Ministries Confidentiality Policy

Life Counseling Center Ministries believes confidentiality is a vital aspect of the counseling relationship. We agree to carefully guard the information entrusted to us by our counselees to the fullest extent possible 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 follow 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 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 Ministries counselors 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 occurs, the counselor will discuss it with the child or adolescent first before talking to the parents or guardians**.** **I understand: ______________ (*please initial*)**

Counseling Agreement

Thank you for your interest in counseling at the Life Counseling Center Ministries. 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. While some of our counselors are licensed mental health workers, we provide faith-based counseling. All our counselors are professionally trained and highly experienced, able to walk alongside you in your struggles and suffering.

- *Fees*

The fee for a 50-minute counseling session is $95 for all ages. 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. Please discuss any special circumstances with the Director. Additional fees may be assessed 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 requested services.

- *Confidentiality*

The Life Counseling Center Ministries is sensitive to the issue of confidentiality. Releasing counseling information without consent violates 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 the counselee and confidentiality is applied to the group as a whole.

- *Scheduling Appointments*

For an initial appointment, contact Life Counseling Center: 443-419-3884 or lccadmin@chapelgate.org

- *Missed Appointments*

As a non-profit ministry, the Life Counseling Center must be a good steward of resources, including time. Therefore, sessions must be cancelled 24 hours in advance or a $60 cancellation fee will be assessed. 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.

____

Signature **Date**

Personal Information

The information below will be given to your counselor before the start of you first appointment. You are not obligated 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
Would you like your pastor informed of situations related to your counseling? ☐ Yes ☐ No
(*Contact only made after consent form signed.*)

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 Easygoing Good-Natured

Introvert Likeable Leader Quiet Submissive Self-Conscious Lonely Sensitive Outgoing

Fearful Anxious Organized People Pleaser Other__________

Have they ever experienced…

- A severe emotional upset, breakdown, loss or life-changing crisis? ☐Yes ☐No
- Suicidal …thoughts? ☐Yes ☐No …plans? ☐Yes ☐No …attempts? ☐Yes ☐No
- Homicidal …thoughts? ☐Yes ☐No …plans? ☐Yes ☐No …attempts? ☐Yes ☐No
- Sexual/physical/mental/emotional abuse? ☐Yes ☐No
- A disturbance in sleeping patterns? ☐Yes ☐No
- Does your child seem to have specific sensory aversions, such as food, texture, or sounds? ☐Yes ☐No
- Does your child seek or avoid touch? ☐Yes ☐No
- Does your child have difficulty with eye contact? ☐Yes ☐No
- Does your child have difficulty with limit-setting? ☐Yes ☐No
- Does your child have a difficulty with handling transitions? ☐Yes ☐No

How hectic is your lifestyle? Would you please describe current family life (i.e. “over-scheduled,” “hurried,” or “stressed”).

____

What calms your child? What upsets your child?

____

____

Please describe any major stressors (deaths, moves, major transitions, etc.) that may have impacted your child: ____

____

____

Any of the following complications during pregnancy with this child (check all that apply):

______Flu or illness
______High Blood Pressure
______Other (e.g., RH incompatibility)
______Hospitalization during pregnancy
______Maternal Injury
______Maternal Abuse
______Medication during pregnancy (what?______________)
______Alcohol during pregnancy (frequency:_____________)
______Cigarettes during pregnancy (frequency:______________)
______Other drugs during pregnancy (type and frequency:_________________)

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

- ☐ Stress
- ☐ Anxiety
- ☐ Panic
- ☐ Depression
- ☐ Apathy
- ☐ Fatigue/Lack of Energy
- ☐ Gender Identity Issues
- ☐ Trouble Sleeping
- ☐ Poor Concentration
- ☐ Feeling Worthless
- ☐ Recent Death
- ☐ Grief
- ☐ Work Stress
- ☐ Chronic Pain
- ☐ Indecisiveness
- ☐ Spiritual Problems
- ☐ Controlling
- ☐ Communication Issues
- ☐ Marital Problems
- ☐ Physical Abuse
- ☐ Emotional Abuse
- ☐ Verbal Abuse
- ☐ Sexual Abuse
- ☐ Sexual Problems
- ☐ Porn Use
- ☐ Anger
- ☐ Aggressive Behavior
- ☐ Bad Dreams
- ☐ Unwanted Memories
- ☐ Fears
- ☐ Shyness
- ☐ Loss of Control
- ☐ Parenting Problems
- ☐ Controlled by Others
- ☐ Guilt/Shame
- ☐ Relational Conflict
- ☐ Compulsive Behaviors
- ☐ Seeing Things Others Don’t
- ☐ Hearing Voices
- ☐ Racing Thoughts
- ☐ Eating Problems
- ☐ Drug Use
- ☐ Loss of Appetite/Overeating
- ☐ Alcohol Use
- ☐ Pregnancy
- ☐ Abortion
- ☐ Legal Matters
- ☐ Loneliness
- ☐ Low Self-Esteem
- ☐ Impulsive Behavior
- ☐ Financial Problems
- ☐ Obsessive Thoughts
- ☐ Other

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

[--]

Very Minimally Distressed	Moderately Distressed	Very Extremely Distressed

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

Where? ____

Approximate date counseling began?____

Approximately how long did this counseling continue?__________________________________

Reason for ending? ____

____