The Hope House Counseling Center

A counseling ministry of the Loganville Community Ministry Village, Inc.

Child / Adolescent Intake Form

Personal Information

Name ____ Age _____ DOB _______

Grade _____________________ School ____

Parents Names: Father: ___________________ Mother: _________________________

Parents Marital Status: _________________ If divorced, who does the child live with? _____________

Address _____________________________ City, State, Zip ________________________________

Home Phone: _________________ Parents Cell: ____________________ which parent? _________

E-mail address ________________________ Where do you prefer to be contacted? ______________

Physical Information

Name of Physician if currently under physicians care ____

Reason for physicians care ________________ Date of last appointment ________________

Is the child currently taking any prescription medication? _________
If yes, please list the medication and dosages below:

Medication & dosage	Date began	Results

Has the child had any previous therapy / counseling? _______
If yes, when? ___________

Name of therapist ____________________ Phone Number: __________________

Results of previous Therapy:

____

____

Briefly describe your current reason for seeking therapy at this time:

____

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How long have you been experiencing the current symptoms?___________________________

Has a particular event precipitated these symptoms?_____ If yes, briefly explain the event____
____
____
____

On a scale of 1-100, with 1 being horrible and 100 being wonderful, where would you rate your current state?______________

Do you regularly attend church? ________ If yes, where? ________________

Does spirituality play an important role in your life?______________________

Do you mind if your counselor prays for/with you during sessions?__________

Please list any factors, that have not been discussed, that you feel may play an important role in your counseling experience
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I hereby authorize the release of my medical records, to agents of the Hope House Counseling Center. I understand that these records will only be used to enhance the therapeutic process and will be kept in strict confidence within my client file.

Client's signature: ______________________________ Date:_____________

Parent or Guardian's Signature:_________________________________Date:_____________________