BIBLICAL COUNSELING INTAKE FORM (Under 18 years)

CHILD/YOUTH'S NAME: _____

PARENT/GAURDIAN'S NAME: _____

PARENT'S CELL PHONE: _____

HOME PHONE: _____

PARENT'S E-MAIL: _____

MAILING ADDRESS:_____

_____

CHILD/YOUTH'S GENDER: _____ CHILD/YOUTH'S BIRTH DATE: _____

CHILD/YOUTH'S AGE: _____

EDUCATION: (Last Grade Completed) _____

SIBLING'S NAMES AND AGES:

_____

_____

_____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

1. Please describe the current problem for which you are seeking Biblical counseling for your child.

_____

_____

_____

_____

_____

_____

_____

2. What have you attempted to do to alleviate your child's problem (if anything)?

_____

_____

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_____

3. What do you hope for your child to achieve through the Biblical counseling process? Briefly list two to three goals.

_____

_____

_____

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_____

4. Have you sought other outside help for your child? If so, from whom?

_____

_____

5. Are you, as a parent, a believer in Jesus Christ? Yes No (circle one)

6. Is the child/youth a believer in Jesus Christ? Yes No (circle one)

7. Please explain the Gospel as you, as a parent, understand it in the space provided below:

_____

_____

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_____

ASSESSMENT

Please check all the behaviors that you have observed in your child/youth:

_____ Sadness
_____ Self-harm
_____ Feels worried
_____ Feels fearful
_____ Has problems getting along with peers
_____ Has problems getting along with adults
_____ Resistant to authority
_____ Struggles with anger
_____ Acts out his/her anger
_____ Holds a grudge
_____ Has been physically abused
_____ Is physically abusive towards others
_____ Has been verbally abused
_____ Is verbally abusive towards others
_____ Has been sexually abused
_____ Has sexually abused another person
_____ Has been exposed to pornography
_____ Is sexually active
_____Has used alcohol
_____ Has used illegal drugs
_____ Has abused prescription drugs
_____Does not attend church regularly
_____ Does not read their Bible often
_____ Jesus is important in your child's life

CHURCH AFFILIATION

1. Is your family a member of a local church? Yes No (circle one)
2. If so, what is the name of the church you attend _____
   how long have you attended this church? _____
3. Is your family actively involved in your church? Yes No (circle one)
4. Does your child have a person/people to whom they are accountable to at your church? Yes No
5. Does your family believe being an active part of a community of believers is important to reaching your goals in biblical counseling? Why? Why not?

_____

_____

_____

6. How did you hear about Spotswood Biblical Counseling Center? _____

EMERGENCIES

We can be reached at 540-940-2940 Monday-Thursday from 10am-3pm. We are not a 24 hour emergency/crisis center. If you are unable to reach us in a timely manner, you should contact your physician, a local emergency room or the local police department when necessary and appropriate. It is your responsibility to seek the appropriate resources in emergency situations. By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. By our signature it verifies the accuracy of this statement and acknowledges my commitment to conform to its specifications.

Child/Youth's Name (Print):_____

Signature of Parent:_____

Date: _____

Biblical Counselor Name (Printed): _____

Signature of Biblical Counselor: _____

Date: _____