

CHRISTIAN COUNSELING ASSOCIATES

A MINISTRY OF CORNERSTONE LODGE, INC.
YOUTH INTAKE SHEET

COUNSELEE INFORMATION

Primary Client _____

| | | | | |
|---------------|-----------|------------|-------|----------|
| | Last Name | First Name | MI | Nickname |
| Address _____ | | | | |
| | Street | City | State | Zip |

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Age _____ Gender _____

May we leave a message at your home? _____ Yes _____ No

Name of other family members:

| | | | | |
|-------|-----------|--------------|--------------------|-------|
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |
| _____ | Age _____ | Gender _____ | Relationship _____ | _____ |

GUARDIAN'S INFORMATION

| | | |
|--|------------|--------------------|
| Name _____ | | Relationship _____ |
| Home Phone _____ | Work _____ | Cell _____ |
| Email _____ | | |
| Date of Birth _____ | Age _____ | Occupation _____ |
| May we call you at your home? _____ Cell? _____ | | |
| May we leave a message at your home? _____ Cell? _____ | | |

| | | |
|--|------------|--------------------|
| Name _____ | | Relationship _____ |
| Home Phone _____ | Work _____ | Cell _____ |
| Email _____ | | |
| Date of Birth _____ | Age _____ | Occupation _____ |
| May we call you at your home? _____ Cell? _____ | | |
| May we leave a message at your home? _____ Cell? _____ | | |

Parents' Current Marital Status (if need to differentiate, then please put an F for Father and M for Mother):

Never Married
 Married
 Engaged
 Divorced
 Separated
 Widowed
 Remarried

Date of Marriage (if applicable) _____

Date of Divorce (if applicable) _____ Date of Death (if applicable) _____

Parents' Education Level (please put an F for Father and M for Mother):

GED
 High School Diploma
 College Degree
 Graduate Degree

Other important family info: _____

For office use:

Therapist: _____

Diagnostic code: _____

Date of first session: _____ fee _____

PERSONAL INFORMATION (to be filled out by parent or guardian regarding youth)

Are you currently attending a church? Yes No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

Do you have a personal relationship with Christ? Yes No Unsure

Are religious or spiritual issues important in your life? Yes No

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? Yes No

If yes, what are they? _____

Would you like prayer as part of your counseling? Yes No

Who referred you to our center? _____

May we contact them? Yes No

How would you rate your health? _____

How many hours do you sleep each night? _____

How would you rate your diet?
 Very Healthy Healthy Average Needs Improvement Poor

Do you have any addictive/abusive issues? Yes No

If so, with what? _____

Has your appetite or weight changed lately? _____

Are you currently on medication? Yes No

If so, please complete the following:

| Medication | Dosage | Physician | Purpose |
|------------|--------|-----------|---------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience. _____

How much are you troubled by this?

Constantly Often Somewhat Not Very Much

Comments concerning this problem: _____

Have you been in counseling before? Yes No

If so, for each incidence you remember, please complete the following:

- Who was the counselor? _____
What was the problem? _____
How many sessions over what period of time? _____
What were the results? _____
- Who was the counselor? _____
What was the problem? _____
How many sessions over what period of time? _____
What were the results? _____
- Who was the counselor? _____
What was the problem? _____
How many sessions over what period of time? _____
What were the results? _____

THOUGHTS AND BEHAVIORS

Parent or Guardian, please check how often you think the following thoughts occur for your child. Feel free to get their input or leave any blank that are not applicable.

- | | | | | | | | | |
|--------------------------------|-----|-------|-----|--------|-----|-----------|-----|------------|
| 1. Life is hopeless. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 2. I am lonely. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 3. No one cares about me. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 4. I am a failure. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 5. Most people don't like me. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 6. I want to die. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 7. I want to hurt someone. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 8. I am so stupid. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 9. I am going crazy. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 10. I can't concentrate. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 11. I am so depressed. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 12. God is disappointed in me. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 13. I can't be forgiven. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 14. Why am I so different? | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 15. I can't do anything right. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 16. People hear my thoughts. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 17. I have no emotions. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 18. Someone is watching me. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 19. I hear voices in my head. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |
| 20. I am out of control. | ___ | Never | ___ | Rarely | ___ | Sometimes | ___ | Frequently |

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

- | | | | |
|------------------------------------|-----|--|-----|
| Excessive anger, easily frustrated | ___ | Hyperactivity | ___ |
| Mood swings (depression-manic) | ___ | Change or loss of friends | ___ |
| Excessive guilt or shame | ___ | Self-mutilation, cutting | ___ |
| Loss of energy | ___ | Eating disorders | ___ |
| Loss of interest in activities | ___ | Excessive stress | ___ |
| Suicidal thoughts | ___ | Anxiety or excessive fears | ___ |
| Suicide attempts (how many) | ___ | Learning disabilities | ___ |
| Lying | ___ | School related problems | ___ |
| Manipulation | ___ | Hallucinations, delusions, thought distortions | ___ |
| Poor impulse control | ___ | Obsessive thoughts &/or compulsive behaviors | ___ |

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name _____
 Address _____
 Home Phone _____ Cell Phone _____