

The Center for Family Counseling and Education

Child Client Pre-intake Information

(This information is to be provided by the parent to CFCE prior to their child's first counseling session)

Parent's personal information

Name (first, middle initial, last):	
Street Address:	
City:	
State:	Postal code:
Phone numbers (include area codes)	
Home:	Cell:
Work:	OK to contact at work? Yes <input type="checkbox"/> No <input type="checkbox"/>
Email address:	
Home:	
Work:	
OK to contact at work? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Male <input type="checkbox"/> Female <input type="checkbox"/>	Age: _____ Date of birth (mm/dd/yyyy): / /
Please check the box following the term(s) which best describe your ethnicity: African <input type="checkbox"/> Asian <input type="checkbox"/> Eastern European <input type="checkbox"/> Far Eastern <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> Near Eastern <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Western European <input type="checkbox"/> Other (describe) <input type="checkbox"/>	
Occupation:	
How long have you been employed at your current place of employment? years months	
Education (please circle the year of the highest level you have completed)	
High school: 9 10 11 12 College: 1 2 3 4 Graduate school: 1 2 3 4 Doctorate: 1 2 3 4	
Diploma(s) and/or degrees earned:	
In case of emergency contact:	
Name (first, middle initial, last):	
Relationship to you:	
Phone number (please include area code):	
Street address:	
City:	
State:	Postal code:
Email address:	Total monthly household income: \$ _____

Parent's marital information

Current marital status

Please check the box(es) following the description(s) that best describe(s) your current marital status: married and cohabiting <input type="checkbox"/> married but living separately <input type="checkbox"/> legally separated <input type="checkbox"/> divorced <input type="checkbox"/> not married but cohabiting <input type="checkbox"/> never married, never cohabited <input type="checkbox"/>	
If married, for how long? years months	Cohabitation prior to marriage? Yes <input type="checkbox"/> No <input type="checkbox"/>
If cohabiting, for how long? years months	Reason(s) for decision to cohabit?

If married, rate your relationship with your spouse: excellent <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor <input type="checkbox"/> unbearable <input type="checkbox"/>
If cohabiting, rate your relationship with your partner: excellent <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor <input type="checkbox"/> unbearable <input type="checkbox"/>
If married, will your spouse be participating in your counseling? Yes <input type="checkbox"/> No <input type="checkbox"/>
If cohabiting, will your partner be participating in your counseling? Yes <input type="checkbox"/> No <input type="checkbox"/>

Marital spouse/cohabitational partner

Name (first, middle initial, last):	
Street address (if different from client's)	
City:	
State:	Postal code:
Phone numbers (please include area codes)	
Home:	Cell:
Work:	OK to contact at work? Yes <input type="checkbox"/> No <input type="checkbox"/>
Age:	Date of birth (mm/dd/yyyy): / /

History

Previous marriage(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please indicate the number of times):
Divorced? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please indicate the number of times)
Death of spouse? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please indicate the number of times)

Child's family information (current cohabitants)

Members of present household (please indicate the number of each currently living with you and your child)			
Children:	Stepchildren:	Foster children:	Grandchildren:
Parents:	Other relatives:	Friends:	

Which terms best describe your current home environment? harmonious battleground peaceful
clamorous orderly chaotic happy unhappy supportive destructive welcoming
hostile

Please check all below who are still living and indicate to the right of the check box how many of each, and place a check in the column beneath the term which best describes your child's present relationship with that person or those people (please leave blank if your child has no relationship with that person or those people):

	Excellent	Good	Fair	Poor	Unbearable
mother <input type="checkbox"/>					
stepmother <input type="checkbox"/>					
father <input type="checkbox"/>					
stepfather <input type="checkbox"/>					
brother(s) <input type="checkbox"/>					
stepbrother(s) <input type="checkbox"/>					
sister(s) <input type="checkbox"/>					
stepsister(s) <input type="checkbox"/>					
Children <input type="checkbox"/>					

Child's personal information

Name (first, middle initial, last):			
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Age:	Date of birth (mm/dd/yyyy): / /
Was your child: born into your family? Yes <input type="checkbox"/> No <input type="checkbox"/> adopted? Yes <input type="checkbox"/> No <input type="checkbox"/> a foster child? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Education (please circle the year of the highest level of school your child has completed)			
Primary school: K4 K 1 2 3 4 5 Middle school: 6 7 8 High school: 9 10 11 12			

Child's medical information

Primary care physician name:	
Street Address:	
City:	
State:	Postal code:
Phone number (please include area code):	

Current medical condition

<p>Please check the box next to the phrase which best describes your child's current physical condition:</p> <p>Excellent health, no health problems or concerns <input type="checkbox"/> Good health, few health problems or concerns <input type="checkbox"/></p> <p>Fair health, several health problems or concerns <input type="checkbox"/> Poor health, many health problems or concerns <input type="checkbox"/></p>
Please list any medical conditions for which your child is currently being treated by a medical professional:
Please list any physical problems (injuries, illnesses, pains, disabilities, etc.) that your child currently has but for which your child is not currently being treated by a medical professional:
Please list any serious medical conditions for which your child has been treated by a medical professional in the past (include surgeries, hospital stays, etc.)
Please list any medications that your child is currently taking:

Child's psychological information

Has your child been diagnosed with a psychological disorder? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Has your child been diagnosed with a developmental disability? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Has your child previously received mental health counseling? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes to any of the above, please provide as much detailed information on the back of this sheet about this experience as possible including dates, durations, types of treatment, name and type of therapist (psychiatrist, psychologist, mental health counselor, social worker, spiritual counselor, etc.), results, and your impressions of the experience.			
Please check any of the following which you feel apply to your child or that you have been told applies to them:			
Depressed <input type="checkbox"/>	Anxious <input type="checkbox"/>	Fearful <input type="checkbox"/>	Isolated <input type="checkbox"/>
Obsessive <input type="checkbox"/>	Unpredictable <input type="checkbox"/>	Domineering <input type="checkbox"/>	Submissive <input type="checkbox"/>
Absent-minded <input type="checkbox"/>	Forgetful <input type="checkbox"/>	Arrogant <input type="checkbox"/>	Abusive <input type="checkbox"/>
Problem keeping this/these feeling(s) under control: Anger <input type="checkbox"/> Irritation <input type="checkbox"/> Worries <input type="checkbox"/> Fear <input type="checkbox"/> Suspicion <input type="checkbox"/> Inadequacy <input type="checkbox"/> Worthlessness <input type="checkbox"/> Helplessness <input type="checkbox"/> Hopelessness <input type="checkbox"/> Superiority <input type="checkbox"/> On top of the world <input type="checkbox"/> Pessimism <input type="checkbox"/>		Experienced(ing) problem(s) with: Addiction(s) <input type="checkbox"/> Distinguishing what is real and what is not <input type="checkbox"/> Uncontrollable thoughts <input type="checkbox"/> Internal voices <input type="checkbox"/> Visual hallucinations <input type="checkbox"/> Audible hallucinations <input type="checkbox"/> Feeling like you are somewhere or someone else <input type="checkbox"/>	

Spiritual information

Please check any of the following which you believe apply to your child:			
Religious <input type="checkbox"/>	Spiritual <input type="checkbox"/>	Agnostic <input type="checkbox"/>	Atheist <input type="checkbox"/>
Interested in learning more about spiritual matters <input type="checkbox"/>		Not interested in spiritual matters <input type="checkbox"/>	
My child believes that the Bible is (check the response or responses which most closely approximates your child's position): Mostly myths and out-of-date-teachings <input type="checkbox"/> A good book <input type="checkbox"/> God's Holy Spirit-breathed Word <input type="checkbox"/> From Genesis 1:1 to Revelation 22:21 the completed self-revelation of God to man in written form <input type="checkbox"/> Absolute, universal, reliable, and eternal truth from God and the final authority for all things regarding my Christian faith and practice <input type="checkbox"/>			
My child believes that God is (check the response or responses which most closely approximates your child's position): Nonexistent <input type="checkbox"/> A concept created by man <input type="checkbox"/> Real but unreachable and/or unknowable <input type="checkbox"/> A higher form of being who evolved by progressive accomplishments and/or improvements <input type="checkbox"/> A combination of what all human religions teach about divine being(s) <input type="checkbox"/> Exactly who he said he is and revealed himself to be in the Bible <input type="checkbox"/>			
Christian <input type="checkbox"/> Church member? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, where? If yes, how long? If yes, how often does your child attend regularly scheduled services? _____ times per week <input type="checkbox"/> month <input type="checkbox"/> year <input type="checkbox"/> If yes, currently active in church ministry? Very <input type="checkbox"/> Somewhat <input type="checkbox"/> No <input type="checkbox"/> If no, interested in joining a church? Yes <input type="checkbox"/> No <input type="checkbox"/>		Other religion/faith <input type="checkbox"/> Please describe:	
If Christian, please check any of the following which you believe apply to your child: Holy Spirit-regenerated (spiritually born-again) <input type="checkbox"/> Date of rebirth: / / New convert <input type="checkbox"/> Committed learner <input type="checkbox"/> Discipled <input type="checkbox"/> Spiritually mature <input type="checkbox"/> Believer's baptism <input type="checkbox"/>			
Sin issues with which your child is currently struggling: Lust <input type="checkbox"/> Immorality <input type="checkbox"/> Envy <input type="checkbox"/> Greed <input type="checkbox"/> Jealousy <input type="checkbox"/> Fear <input type="checkbox"/> Unrighteous Anger <input type="checkbox"/> Lack of forgiveness <input type="checkbox"/> Lack of consistency <input type="checkbox"/>			
How often does your child meditate on scripture? _____ times each day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/>			
How often does your child communicate with God in prayer? _____ times each day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/>			
Is your child involved in a mentoring/accountability relationship with a more mature Christian? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, would your child be interested in becoming involved in such a relationship? Yes <input type="checkbox"/> No <input type="checkbox"/>			