Shontel Thomas, Christian Counselor and Life Coach

Restoration Christian Wellness Center (RCWC)

Business Line: (732) 357-2880

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescent please fill out FIRST HALF of session that says adolescents. Parent/guardian please fill out remaining.

CONFIDENTIAL ADOLESCENT INTAKE FORM (ages 12-18)

CLIENT INFORMATION Name:_____

Date of Birth _____ Age: _____ ❒ Male ❒ Female

Physical Address:

_____

Mailing Address:

_____

Phone (Cell): _____

Messages okay?_____ Phone (Home):

_____ Messages okay?_____

School: _____

Grade: _____

Race/Ethnic Origin: _____

Religious Preference _____

PERSONAL STRENGTHS What activities do you enjoy and feel you are successful when you try?

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

CURRENT REASON FOR SEEKING COUNSELING?

What would you like to see happen as a result of counseling?

COUNSELING/MEDICAL HISTORY Have you previously seen a counselor? ❒Yes ❒No

CHEMICAL USE AND HISTORY Do you currently use alcohol or other drugs? ❒Yes ❒No If yes which one?

FAMILY HISTORY

Are your parents married or divorced? _____

Do you think their relationship is good? (Y/N/Unsure)_____

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

Fighting Disagreeing about relatives_____

Feeling distant Disagreeing about friends_____

Loss of fun_____

Alcohol or Drug use_____

Lack of honesty_____

Trauma_____

Medical Concerns_____

Education problems_____

Divorce/separation_____

Financial problems_____

Issues regarding remarriage_____

Death of a family member_____

Birth of a child_____

Job change or job dissatisfaction_____

Inadequate housing/feeling unsafe_____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation?
Are you happy with the amount of friends you have? (Y/N) Have you ever been bullied? (Y/N)
Are your parents happy with your friends? (Y/N)

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent'sName: _____

Date of Birth: _____

Mother's/Guardian'sName_____ Phone Contact:_____
Address_____

Father's/Guardian's Name_____ Phone Contact:_____
Address:_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Who lives with you? Relationship to you and age?

Current Reason For Seeking Counseling For Your Adolescent

COUNSELING HISTORY: Have your son or daughter previously seen a counselor? ❒Yes ❒No If Yes, where: _____Approximate Dates of Counseling:
For what reason did your son or daughter go to counseling?

Does your son or daughter have a previous mental health diagnosis?

What did you find most helpful in therapy?

What did you find least helpful in therapy?

Has your son or daughter used psychiatric services? ❒Yes ❒No If Yes, where:

CHILD'S DEVELOPMENT: Were there any complications with the pregnancy or delivery of your child? ❒Yes ❒No If Yes, describe please

Did your child have health problems at birth? ❒Yes ❒No If Yes, describe please

Has your child experienced emotional, physical, or sexual abuse? ❒Yes ❒No ❒Not sure , If Yes, describe please

PARENT'S MARITAL STATUS ❒ Single ❒Married (legally) ❒Divorced ❒Cohabitating

❒Divorce in process ❒Separated ❒Widowed ❒Other
Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____ If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

AGREEMENT FOR SERVICE / INFORMED CONSENT

This document contains important information about my professional services and business policies, including limits of confidentiality. Please read it carefully. When you sign this document, it will represent an agreement between us.

Risks and Benefits of Therapy. Participating in therapy can result in a number of benefits to you, including a deeper understanding of yourself and your personal goals, improved relationships with others, and resolution of the specific concerns that are your motivation for beginning therapy. However, therapy can have risks as well as benefits. While the primary goal of therapy may be to improve your well-being, it can also result in considerable discomfort. You may experience uncomfortable feelings such as sadness, guilt, anger, shame, frustration, loneliness, and helplessness. Should you have any concerns regarding your progress in therapy, it is important to let me know

Confidentiality. The information disclosed by you in therapy is generally confidential and will not be released to others without your written consent. However, there are a few exceptions. Exceptions to confidentiality, include:

• If there is reason to believe a child, elderly person, or dependent adult is or has been abused.

• If you threaten to commit serious bodily harm to yourself or another person.

• If I am presented with a subpoena or court order that has been signed by a judge.

In any of the above circumstances, I will only reveal the minimum information that is necessary, and I will do my best to inform you of the information being disclosed and to whom it will be provided before I do so.

Minors and Confidentiality. If you are a minor, under the age of 18, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Cancellation Policy. Standard policy for most therapists, myself included, is a 24 hour cancellation policy. If you do not show up for your scheduled therapy appointment, and have not notified me at least 24- hours in advance, payment will be required for the full cost of the session.

Therapist Availability and Emergencies. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee your call will be returned immediately. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911.

CONSENT TO TREATMENT

I, _____, have read Agreement for Services/Informed Consent. In signing below, I consent to treatment and agree to abide by its terms during the course of therapy.

Patient Name (please print)

_____

Signature of Patient_____ (or authorized representative) Date_____

Parental Consent to Treat a Minor

I, _____ (Name of Parent or guardian of child), give my permission for my child, _____ (Full Name of Minor), _____ (Birth Date of Minor), to be treated by **Shontel Thomas, Christian Counselor/ Certified Life Coach**. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____ (Date consent expires).

Parent or guardian's signature Relationship to minor Today's date

_____