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 _____
Insurance Carrier: _____ Y or N

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:

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____
3. 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 _____