The iHope Christian Care & Counseling Center
1414 W. Evans St., Florence, SC 29501
(843) 702-0323
www.ihopeflorence.com

# Client Intake Form (Child)

**Date** _____

*This information is confidential and will not be shared with any third party unless required by law as stated in the Informed Consent.*

Client (Child) Name: _____
Please print first and last name (Indicate preferred nickname if needed)

Parent/Guardian Name(s): _____

Mailing Address: _____

Parent Phone: (H)_____ (C)_____ (W)_____

Parent Email: _____

Preferred Contact Method: _____

Where are you comfortable with iHope leave a voicemail? ____home ____cell ____work

May iHope send session reminders via: ____text message ____email ____only by phone call

Child's Date of Birth: _____/_____/_____ Age: _____ Gender: _____

School: _____ Current Grade: _____

Parents: ☐ Single ☐ Married ☐ Divorced ☐ Deceased ☐ Blended/Step family

Siblings (name/ages): _____

Who lives in the child's home? _____

**In case of emergency, contact:**

Name: _____ Relationship: _____ Phone: _____

*Please sign to give consent for us to contact this person in an emergency:* _____

## REASON FOR COUNSELING

Please briefly explain why you are bringing your child to counseling: _____

_____

What do you hope to gain here (how you hope life will change): _____

_____

Where do you see these concerns impacting your child the most today? (mark all that apply)

☐ Home ☐ School ☐ Siblings ☐ Parents ☐ God ☐ Other _____

## INTEGRATION OF FAITH IN THE COUNSELING PROCESS

How important is your faith/spirituality to <u>you?</u> ☐ Very ☐ Moderate ☐ Little ☐ Not at all

to <u>your child?</u> ☐ Very ☐ Moderate ☐ Little ☐ Not at all

Are you active in your church? ☐ Very ☐ Somewhat ☐ No ☐ I/We would like to be more active

Church membership/affiliation _____

## MEDICAL AND COUNSELING HISTORY (OF CHILD)

Physician Name/Contact info: _____ Date of last physical: _____

Current medications (prescription name and dosage): _____

_____

Has your child been hospitalized in the past 18 months? ☐ Yes ☐ No *If yes, please indicate the reason and duration of stay:* _____

Has your child received therapy/counseling or psychiatric care in the past 2 years? ☐ Yes ☐ No

*If yes, please indicate where, why, and when:* _____

*Would you be willing for us to talk with the previous provider?* ☐ Yes ☐ No ☐ Maybe

Please describe your child's current physical health:

Sleep: _____ Diet: _____

Exercise: _____ Physical complaints: _____

Use of alcohol, tobacco, or drugs: _____

Other physical/medical concerns: _____

## AREAS OF CONCERN *(mark all that apply)*:

| | | |
|---|---|---|
| ☐ Depressed mood | ☐ Difficulty concentrating | ☐ Fear |
| ☐ Anxiety/excessive worry | ☐ Difficulty organizing/losing things | ☐ Fatigue |
| ☐ Weight/Appetite changes | ☐ Feelings of panic | ☐ Confusion |
| ☐ Grief | ☐ Easily upset/on edge | ☐ Medical Problems |
| ☐ Stress | ☐ Fear of social situations | ☐ Bullying |
| ☐ Sleep problems | ☐ Excessive use of media/technology | ☐ Alcohol and/or drug use |
| ☐ Anger/frustration | ☐ Relationships with _____ | ☐ Loneliness/Lack of Friends |
| ☐ Mood swings | ☐ Repetitive behaviors | ☐ Pornography use |
| ☐ Defiant/Oppositional | ☐ Recurrent undesirable thoughts | ☐ Gambling |
| ☐ Negative Peers | ☐ Self-harm | ☐ Impulsivity |
| ☐ Gender/Sexuality concerns | ☐ Suicidal thoughts or attempts | ☐ School |
| ☐ Spiritual problems/faith | ☐ Self-Esteem | ☐ Family transition/change |

☐ Other _____

**Is there anything else you'd like to tell us here?** _____

_____

_____