**Shontel Thomas, Christian Counselor and Life Coach**
**Business Line: (470) 210-8076**

*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)

_____

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_____

_

**CURRENT REASON FOR SEEKING COUNSELING** Briefly describe the problem for which you are seeking counseling?

_____

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_____

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

_____

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_____

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

If yes, what did you find most helpful in therapy? _____

_____

_ If yes, what did you find least helpful in therapy? _____

_____

_

**CHEMICAL USE AND HISTORY** Do you currently use alcohol? _____Yes _____No If yes, how often do you drink? _____Daily _____Weekly _____Occasionally _____Rarely If yes, how much do you drink? _____(#) per time. Do you currently use Tobacco? _____Yes _____No If yes, how much do you smoke/chew? _____ Do you currently use any other drugs? _____Yes _____No If yes, what drugs do you use? _____ If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely Have you received any previous treatment for chemical use? Y/N _____ If so, where did you go?_____ ____Inpatient ____Outpatient

**ADOLESCENTS**

(please answer the following with Y/N) Have you ever used more than 1 chemical at the same time to get high? _____ Do you avoid family activities so you can use? _____ Do you have a group of friends who also use? _____ Do you use to improve your emotions such as when you feel sad or depressed?? _____

**LEGAL ISSUES**

Please list any legal issues that are affecting you or your family at present, or have had a significant

effect upon you in the past.

_____

**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_____

Other concerns not listed above _____

**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)_____ Are involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY Do you like school? (Y/N)_____ Do you attend regularly? (Y/N)_____ What are your current grades? _____ Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know: _____

_____

_

_____

***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?

**(If additional space is need please list on the back of page)**

**Current Reason For Seeking Counseling For Your Adolescent** Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_

_____

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

_____

_

_____

_ What is most concerning right now?

_____

_____

_

**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, who did they see?
_____
_ If yes, was it helpful? N/A____ Yes____ No_____ Has your son or daughter taken medication for a mental health concern? Yes_____ No _____ Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____ If so, please describe:
_____

**CHILD'S DEVELOPMENT** Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:
_____
_
_____
_ Did your child have health problems at birth? Yes _____ No _____ If yes, describe:
_____
_
_____
_ Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure_____ If yes, describe:
_____
_
_____
_ Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___ Not sure_____ If yes, describe:
_____

_

_____

_ Has your child experienced emotional, physical, or sexual abuse? Yes ____ No ____ Not sure _____ If yes, describe:

_____

_

_____

_

**CHEMICAL USE** Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____ If yes, please explain your concern:

_____

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_____

_

**INTERNET/ELECTRONIC COMMUNICATIONS USAGE** Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____ If yes, please explain your concern:

_____

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**LEGAL ISSUES** Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

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_____

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**FAMILY HISTORY** (Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.) Father's Name: _____Birth Date:_____ Age: _____ Ethnic Origin: _____ Total years of education completed: _____ Occupation: _____ Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____
Mother's Name: _____Birth Date:_____ Age: _____ Ethnic Origin: _____ Total years of education completed: _____ Occupation: _____
Place of Employment:
_____ Military experience? Y/N _____ Combat experience? Y/N _____ Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

**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 _____%

**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_____

Other concerns not listed above _____

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____

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_____

_ 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:

_____

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_____

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**YOUR ADOLESCENT'S STRENGTHS:** What activities do you feel your son or daughter is successful when they try?

_____

_
_____

_ What personal qualities would you say your son or daughter has?

_____

_
_____

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

_____

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_____

_
Is there anything else you would like me to know:
_____

_____

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_____

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**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

_____