



Consent to Treat a Minor

Name of minor client: _____ Date of Birth: _____

AGREEMENT FOR PARTICIPATION

We would like to welcome you to our office. We exist as God's hand reaching out to the broken and hurting by providing, at no cost, emotional, and spiritual assistance. Our counseling services have NO cost to the recipient at any time.

- A full counseling session typically lasts 50-55 minutes.
- Counseling can be provided at our main office, client's school or area churches.
- To serve the better interests of all clients, some cases may require a referral.
- Referrals are subject to fees.
- Participation is voluntary.
- Services to be received: Biblically-based counseling, consulting, and intervention.

CONSENT FOR PARTICIPATION

I hereby authorize Beacon of Hope Ministries to provide the following services to the minor listed above: outpatient counseling that will include spiritual interventions introduced in a time and manner that will most benefit the client. These practices may include prayer for and with the clients, Bible reading and reference, the use of Biblical imagery, and assistance with spiritual formation and discipline.

CONFIDENTIALITY

It is important for the minor client to build a trusting relationship with his or her counselor in order for counseling to be viewed as a safe place. All parents and guardians are invited to participate in the counseling process. The extent of your involvement will be based on the discretion of the counselor and the developmental stage of the minor. Any information provided by one parent or guardian may be shared with the other parent or guardian at the discretion of the counselor.

I understand and agree that the minor client's disclosures and communications are considered privileged and confidential except to the extent that I authorize the release of information, or under certain conditions outlined in the following:

- Where harmful neglect or abuse of children or others is suspected.
- Where imminent danger to the client or community is known.

COURT INVOLVEMENT

The minor's counselor will not engage in communication with attorneys or mediators for either parent or guardian. In order to preserve the counseling relationship, the counselor will not provide custody or visitation recommendations, unless all legal guardians and the counselor agree it is in the best interest of the minor, or counseling records are subpoenaed.

I have [Joint / Full] **legal custody and/or [Joint / Full] **physical custody** of the minor listed below:

I understand that I may revoke this authorization by submitting my request in writing to Beacon of Hope.

Signature of Parent or Legal Guardian

Name (please print)

Date

Witness

Date

**In cases of joint custody, consent from all parents or guardians are required in order to treat a minor, except in emergencies.

CHILD AND ADOLESCENT INTAKE FORM

Personal Information:

Name: _____ Date: _____

Gender: _____ Ethnic Origin: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Emergency contact 1: _____ Ph #: _____ Relationship: _____

Emergency contact 2: _____ Ph #: _____ Relationship: _____

School/Daycare: _____ Grade: _____

People living in same household as child:

Name	Age	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Presenting Problems:

Check any areas in which you have concerns for your child:

- | | | |
|--|---|--|
| <input type="checkbox"/> Physical health | <input type="checkbox"/> Separation anxiety | <input type="checkbox"/> Aggressive behaviors |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Hurting animals |
| <input type="checkbox"/> Diet and eating | <input type="checkbox"/> Nervous habits | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Hygiene | <input type="checkbox"/> Anxiety / Fear | <input type="checkbox"/> Delinquent behaviors |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Grief | <input type="checkbox"/> Legal situation |
| <input type="checkbox"/> Motor skills | <input type="checkbox"/> Depression | <input type="checkbox"/> Concentration / Attention |
| <input type="checkbox"/> Language skills | <input type="checkbox"/> Self – harm | <input type="checkbox"/> School |
| <input type="checkbox"/> Memory issues | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Sensory issues | <input type="checkbox"/> Alcohol / Drug use | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Potty training | <input type="checkbox"/> Sexual acting out | |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Anger | |

Explain the item(s) you checked (continued on next page):

What made you decide to take your child to counseling? What are your goals for counseling?

What are some of your child's strengths?

What discipline is used in the home?

Please describe how your child gets along with his or her family.

Please describe your child's relationship with his or her friends/peers.

Has your child experienced any significant changes in the last year? (changed schools, new people in the home, loss of pet).

Medical History:

Has your child previously or currently been under the care of a psychiatrist? Yes No

Name of Psychiatrist: _____

Agency/Practice: _____ Dates seen: _____

Has your child received mental health treatment in the past? Yes No

If yes, for what, when and where? _____

Is your child currently on medication? Yes No

Name of Medication	Reason for Medication	Prescribing Physician
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Primary Care Physician or Pediatrician: _____

When was your child's last physical exam: _____

Does your child have any known medical conditions or allergies? Yes No

If yes, please indicate these conditions: _____

Developmental History:

Did your child or their birth mother experience any complications with birth, delivery or immediately after birth? Yes No

If yes, specify: _____

Did the birth mother experience any physical or emotional abuse, consume alcoholic beverages or abuse any street drugs during pregnancy? Yes No

If yes, specify: _____

Is there any family history of mental health concerns or substance abuse? Yes No

If yes, specify: _____

Has your child experienced any history of physical, sexual or emotional abuse? Yes No

If yes, specify: _____

Has your child experienced a history of prolonged separations, including adoption or foster care?

Yes No

If yes, specify: _____

Has your child been exposed to any other traumatic events? (an accident or injury, loss of a loved one, witnessing domestic violence). Yes No

If yes, specify: _____

Did your child experience any developmental delays? (i.e. talking, crawling, walking, potty training, etc.)

Yes No

If yes, specify: _____

Is your child currently receiving special services at school? Yes No

If yes, specify: _____

Has your child ever failed a class or been held back for academic reasons? Are there any current academic concerns? Yes No

If yes, specify: _____

