Beacon of Hope
A Christ-Centered Counseling Ministry

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 sessions have NO cost to the recipient at any time.

- A full counseling session typically lasts 50-55 minutes.
- 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.

COUNSELING GOALS

Beacon of Hope believes in working in cooperation to develop a clear picture of goals for the minor's counseling. We are committed to honoring your time by having a plan for counseling. We will review this plan with you on a monthly basis. Our hope is that upon conclusion of counseling services, the minor is able to carry what they have experienced and learned in counseling on towards a better future.

CONFIDENTIALITY

It is important for the minor client to build a trusting relationship with their 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 <u>all</u> 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:

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

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 you 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: _____
_____
_____