SOARING to FREEDOM
CHRIST-CENTERED COUNSELING

Child/Adolescent Contact Information

Date: _____/_____/_____
(mm/dd/yyyy)

First Name: _____ Middle Name: _____ Last Name: _____

Nickname: _____ Gender: _____ Birthdate: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Race/Ethnicity:
(Check all that apply)

Asian/Pacific Islander | African-American/Black | Native American
White/Caucasian | Latino/Hispanic | Decline to specify

Pediatrician/Family Practice/Primary Care Provider

PCP Name: _____ PCP Group *(if applicable)*: _____

PCP Phone #: _____ Fax #: _____

Contact Phone Numbers

Please complete relevant information.

Name: _____ Father Mother Other: _____ Legal Custody: Y N
Phone #1: _____ Home Work Mobile Ok to leave message? Y N
Phone #2: _____ Home Work Mobile Ok to leave message? Y N

Name: _____ Father Mother Other: _____ Legal Custody: Y N
Phone #1: _____ Home Work Mobile Ok to leave message? Y N
Phone #2: _____ Home Work Mobile Ok to leave message? Y N

Name: _____ Father Mother Other: _____ Legal Custody: Y N
Phone #1: _____ Home Work Mobile Ok to leave message? Y N
Phone #2: _____ Home Work Mobile Ok to leave message? Y N

Youth contact information (if applicable)

Phone: _____ Home Work Mobile Ok to leave message? Y N

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Name: _____

Mental Health Information

In the past two weeks, how often have you experienced the following? Please select your answers.

	None/Rarely	Sometimes	Often
Had problems paying attention when in class, doing homework, reading a book or playing a game?			
Fidgeted or squirmed with hands or feet when you had to sit still for a long time?			
Felt little interest or pleasure in doing things (especially what you used to enjoy)?			
Felt down, depressed or hopeless?			
Not been able to stop or control worrying?			
Been irritable, argued or become easily annoyed?			
Disobeyed adults including those that aren't your parents?			
Blamed or annoyed others?			
Had thoughts about killing or hurting yourself?			
Had thoughts about hurting someone else?			
Been threatened or hurt by someone else?			

	Yes	No	Unknown
At any time in your life, have you ever hurt or tried to kill yourself?			

At any time in your life, have you experienced the following? Please select your answers.

	Yes	No	Unknown
Had an alcoholic beverage (beer, wine, liquor, etc.)?			
Smoked or used drugs (marijuana, meth, etc.)?			

Additional Notes:

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Name: _____

Please select your answers. **Yes** **No**

At any time in your life, have you had any experience that was so frightening, horrible or upsetting that you

had nightmares or thought about it when you didn't want to? .....

tried hard not to think about it or avoided situations that reminded you of it? .....

were constantly on guard, watchful or easily startled? .....

felt numb or detached from others, activities or your surroundings? .....

Please check if you have experienced any of the following types of trauma or loss.

Emotional abuse	Neglect	Lived in a foster home	Immigration Trauma
Sexual abuse	Homelessness	Multiple family moves	Human trafficking
Physical abuse	Crime victim	Violence in the home	Gang violence
Loss of a loved one	Parent illness	Parent substance abuse	Witnessed death
Bullying	Other: _____		

Medical Information

Month/year of last physical exam: _____/_____ Pediatrician: _____

Do you have any chronic medical conditions?..... **Yes** **No**

If yes, please list. _____

Do you have any CURRENT health concerns?..... **Yes** **No**

If yes, please list. _____

Current prescription medications: None

MEDICATION	DOSAGE	DATE FIRST PRESCRIBED	PRESCRIBED BY

Current over-the-counter medications (including vitamins, herbal remedies, etc): _____

Do you have allergies and/or adverse reactions to medications? **Yes** **No**

If yes, please list. _____

Additional Notes:

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Name: _____

School Information

Current grade/placement: _____ Current School: _____

School Counselor's Name: _____

	Yes	No	Unknown
Is the School Counselor currently involved?			
Do you have an IEP or 504?			
Are you having difficulties with academic performance (grades)?			
Are you having difficulties at school with your behavior (referrals, detentions, etc)?			
Are you having difficulties at school with peers?			

Family and Developmental History

Please list the individuals in your family. Continue on the back of this page, if needed.

NAME	RELATIONSHIP TO YOU	AGE	LIVES WITH YOU?	QUALITY OF RELATIONSHIP	MENTAL HEALTH DIAGNOSIS?

	Yes	No	Unknown
During your mother's pregnancy and your birth, were there medical problems? (gestational diabetes, parent substance use, etc.)			
Did you experience developmental delays (walking, talking tolieting, etc.)?			

If yes to either, please describe. _____

_____

Additional Notes:

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Name: _____

Social/Cultural Information

	Yes	No	Unknown
Do you have challenges finding support (from family, friends, etc.)?			
Are you experiencing any difficulties or concerns due to race, culture, sexual orientation, gender, gender identity, age or ethnic issues?			

If yes, please describe. _____

_____

Sexual Orientation (optional): _____

Please describe your spirituality, religion, or worldview. _____

_____

Please list your strengths, skills and talents. _____

_____

_____

List any special areas of interest or hobbies (art, books, physical fitness, etc.). _____

_____

_____

How many hours of recreational screen time use per week: _____

Legal Information

	Yes	No	Unknown
Are your parents legally separated or divorced or not married?			

If yes, please describe the current custody/visitation plan. _____

_____

Is your custody currently being reviewed in court?			
Have you ever been a ward of the court or involved in foster care?			
Have you ever been charged with a legal offense or in juvenile services?			

If yes to any of the above, please describe. _____

Please describe any additional information or concerns you feel your provider should know.

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Youth Intake Form

Name: _____ Date: _____

Presenting Problem and Treatment Planning

Describe the problem that brought you here today. _____

_____

_____

When did you first notice this problem? _____

_____

_____

Describe any treatment you have tried for this problem or other problems.

Type	WHEN (start – finish)	WHERE	WHY
Outpatient Counseling			
Medication (mental health)			
Psychiatric hospitalization			
Drug/alcohol treatment			
Self-help/support groups			

Additional Notes:

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Treatment Process

Services at Soaring to Freedom start with an assessment. Your counselor will talk with you about your current situation, ask you about your history, and make a recommendation for services. You will then develop a "treatment plan" together that outlines how services will go and what outcomes are expected.

Individual sessions usually last 20–30 minutes. They may be weekly or less than weekly. The frequency of sessions will likely decrease over time. Your clinician will talk with you about what is recommended for you.

If you and your counselor believe that psychiatric medications might be helpful, your clinician can make a referral to your family physician.

Risks & Benefits

Mental health services are generally effective in treating most mental health conditions. We review outcomes and find that most people benefit from therapy and/or medications. Few people get worse ffrom treatment. Improvements do require attending appointments and following through with recommendations.

When we develop a treatment plan with you, we will discuss risks and benefits more.

Minor Consent

Anyone under the age of 18 years must have parental consent for counsel, unless they have made previous arrangements with counselor and have written documents to attest to their personal accountability.

Rights & Responsibilities

We recognize the following rights:

- Be treated with dignity and respect. Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability.

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ACKNOWLEDGEMENT OF INFORMED CONSENT, RIGHTS & RESPONSIBILITIES, COMPLAINTS PROCESS, AND PRIVACY POLICIES

Print Client Name: _____ Client Date of Birth: _____

If Parent/Guardian, print name: _____ Parent Guardian Other

Informed Consent **INITIAL**

I have read and understand the risks & benefits related to treatment and evaluation by Soaring to Freedom. I consent to receive mental health services by Soaring to Freedom. Any questions I have regarding these have been answered.

Rights & Responsibilities and Complaints/Grievances **INITIAL**

I have reviewed and understand my rights and responsibilities and the Complaint/Grievance process for services at Soaring to Freedom. This includes complaints, fees, no-show/cancellation policies, and my rights. I have a copy of these rights and responsibilities. Any questions on these have been answered.

Notice of Privacy Practices **INITIAL**

I have reviewed Soaring to Freedom's privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have a copy of these policies. I understand that Soaring to Freedom will share basic information with my primary care provider unless I ask to "restrict" this disclosure.

Financial **INITIAL**

If I cancel within 24 hours or do not show for an appointment, I will pay $35. I am the, financial guarantor", meaning I will be responsible for payment.

Signature of Client or
Parent/Guardian: _____ Date: _____