

White River Christian Church

Counseling Information Teen Form

**Your right to privacy protects this form and its content.
It cannot be released to anyone except by your written permission.**

PERSONAL Information:

Name _____ Birth Date _____

Address _____ Home Phone _____ Cell Phone _____

_____ Referred by: _____

Employer _____ Position _____

Education (last yr. Completed or degree) _____

In case of emergency contact _____

Family Information:

Father _____ Birth Date _____ Mother _____ Birth Date _____

Father's Occupation _____ How Long ____ Mother's Occupation _____ How Long _____

Education (last yr. Completed or degree) Father _____ Mother _____

Date of Marriage _____ Divorced _____ Single Parent _____

Traditional Family _____ Blended Family _____

If Blended Family: Step-Father _____ Step-Mother _____

List siblings:

Name _____ Male/Female Age: _____ Step Sister ____ Step Brother ____

Name _____ Male/Female Age: _____ Step Sister ____ Step Brother ____

Name _____ Male/Female Age: _____ Step Sister ____ Step Brother ____

Name _____ Male/Female Age: _____ StepSister ____ Step Brother ____

Other important relationships _____

If your parents have been married previously or had children from previous relationships, please fill out the following information:

Father -

Former Spouse's first name _____ Death ____ Divorce ____

Married from Month/Yr. _____ To Month/Yr. _____

Children: _____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

Other important relationships of father: _____

Mother -

Former Spouse's first name _____ Death ____ Divorce ____

Married from Month/Yr. _____ To Month/Yr. _____

Children: _____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

_____ Male/Female Age: ____ Living with: _____ Deceased _____

Other important relationships of mother: _____

Health:

Describe your health _____

Do you have any chronic conditions _____ What _____

Current medications and dosage _____

Do you drink alcoholic beverages _____ If so, how frequently and how much _____

Do you currently or have you in the past used drugs other than for medical purposes? _____

Have you ever had a **severe** emotional upset _____ If yes, please explain _____

Have you ever seen a psychiatrist or counselor _____ If yes, please explain _____

Spiritual Life:

Do you believe in God ___ Yes ___ Yes but I have doubts ___ No

Would you say you are a Christian ___ Yes ___ In the Process ___ No

Do you pray regularly _____ Do you read the Bible regularly _____

Church you attend _____ Member ___ Yes ___ No

Number of Sunday's you attend Church each month ___ Every Sunday ___ Once ___ Twice

Is there anything that your counselor should know about your spiritual life _____

Emotional Health:

CIRCLE any of the following words which best describe you now: Active Ambitious
 Moody Self-confident Persistent Nervous Hardworking Impatient
 Impulsive Kindly Often-blue Excitable Imaginative Calm Serious
 Easy-going Shy Good-natured Introvert Extrovert Likeable Leader
 Quiet Hard-boiled Submissive Spiritual Self-conscious Lonely Sensitive
 Fearful Anxious Regimented

Problem Check List

<input type="checkbox"/> Anger	<input type="checkbox"/> Envy	<input type="checkbox"/> Appetite	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Fear	<input type="checkbox"/> Memory	<input type="checkbox"/> Apathy	<input type="checkbox"/> Over Eating
<input type="checkbox"/> Moodiness	<input type="checkbox"/> Bitterness	<input type="checkbox"/> Guilt	<input type="checkbox"/> Rebellion
<input type="checkbox"/> Health	<input type="checkbox"/> Sex	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Change in lifestyle
<input type="checkbox"/> Drugs	<input type="checkbox"/> Depression	<input type="checkbox"/> Abuse	<input type="checkbox"/> Smoking
<input type="checkbox"/> Deception	<input type="checkbox"/> Grief	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Blended Family
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Jealousy	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Problems in School

Briefly answer the following questions:

1. What brings you to counseling? _____
 2. What have you already tried to do about this? _____
 3. What are your expectations from counseling? _____
 4. Is there any information that is very important for the counselor to know? _____
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