**For best results, save this form to your computer, view and complete it in Adobe Acrobat. Don't have Acrobat? Click here to get the free Acrobat Reader.

# ANTIOCH COUNSELING SERVICES (ACS) CONFIDENTIAL INTAKE FORM [MINOR]

**Answer all information as completely as possible. Complete one (1) form for each child who will be in counseling.**

Name ______________________________ DOB ____________ AGE ________

Gender: Male Female Antioch member: Yes No

If not name of person who is an Antioch member: ______________________________

Address where child resides ______________________________

Child's school ______________________________ Current grade level: ____________

Current school performance: A B C D Current school behavior A B C D Current attitude A B C D

**LIST YOUR CHILD'S ACTIVITIES BELOW, INCLUDE CHURCH, SCHOOL AND COMMUNITY**

| Activity | In a leadership position | How long involved in this activity |
|---|---|---|
| | | |
| | | |
| | | |

**PARENT/GUARDIAN INFORMATION:**

Parent's marital status: ____________________ Do both parents agree that child should receive counseling? Yes No

Father/Guardian ______________________________ Age ______ Occupation ______________________

Mother/Guardian ______________________________ Age ______ Occupation ______________________

Parent/Guardian's contact Information: This information is for: Mother Father Both Guardian

Home/cell Phone May we leave messages? Yes No

Work Phone May we leave messages? Yes No

E-Mail: May we leave messages? Yes No

Is there any legal action involving this child? Yes No If so, please identify:

**CHILDREN IN FAMILY: PLEASE INDICATE IN BIRTH ORDER**

| Name | Age | Relationship to Client | In home | Not in home |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## CHILD'S PRESENT SITUATION

Why are you seeking counseling for your child? ______________________________

How long has this been an issue? ______________________________

Any major changes in last 6 months {ex. Divorce, move, etc.) ______________________________

Rate your current level of distress with your child on a scale of 1 to 10: 1 ***(little distress)*** to 10 ***(extreme distress)***

What do you want to see happen as a result of counseling? ______________________________

______________________________

What have you tried to solve your concern(s)? ______________________________

What is the condition/s of your child's health? **(check one)** Excellent Good Fair Poor

List primary health issues or injuries ______________________________

Is he or she currently taking prescription medication? Yes No If Yes, list below:

| Name of Prescription | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has your child ever been diagnosed with a learning disability or mental illness? Yes No What?

If yes, does your child receive 504 accommodations at his/her school? Yes No If Yes, explain:

______________________________

Does your child have a history of substance abuse? Yes No What?

Has your child had any counseling in the past? Yes No If yes, when: From to

What was the outcome of counseling? Issue resolved Issue partially resolved Issue unresolved Stopped attending

Has anyone else in the family experienced similar problem? ______________________________

Parent/Guardian Signature/Date: ______________________ Print Name ______________________

Parent/Guardian Signature/Date: ______________________ Print Name: ______________________

## IMPACT OF PROBLEMS ON FAMILY

Read each of the items below. Write in the number that corresponds with the level of impact your child's problem has in each area.

**0** - **No impact**

**1 - Slight Impact**

**2 - More than slight impact, but less than moderate**

**3 - Moderate**

**4 - More than Moderate**

**5 - Serious impact**

| | | | |
|---|---|---|---|
| | 1. Time mother spends with other children in the family | | 12. Visiting friends in their homes |
| | 2. Time father spends with other children in the family | | 13. Emotional well being of mother |
| | 3. Amount of time mother spends with father | | 14. Emotional well being of father |
| | 4. Amount of time father spends with mother | | 15. Emotional well being of brothers) and sister(s) |
| | 5. Family time spent with relatives | | 16. Family finances |
| | 6. Going out to eat as a family | | 17. Relationship between parents |
| | 7. Going out as a family other than to eat | | 18. Relationships among the children of the family |
| | 8. Going on a family vacation | | 19. Relationship between child and parents |
| | 9. Having friends visit our home | | 20. Relationship between parents and the other children in the family |
| | 10. Going to church | | 21. Leaving children in church nursery or other church activities |
| | 11. Frequently leaving work | | 22..Frequently being called to school |

Parent/Legal Guardian Name ______________________

Parent/Legal Guardian Signature ______________________

Today's Date: ______________________

# ANTIOCH COUNSELING SERVICES (ACS)
# CHILD PROBLEM CHECKLIST

Name: ___________________________________________ Age ________ Date ______

Male Female

Circle any items that are very significant. Indicate severity of those items (1-mild, 2- moderate, 3-severe).

Adjustment to life changes (parents' divorce, loss/death of someone close, etc...)
Bedwetting
Abuse (physical, emotional, sexual)
Aggressiveness
Anger
Bullying others/being bullied
Behavior problems
Disobedient/refusing to comply
Disturbing memories (past abuse, neglect or other traumatic experience)
Drug or alcohol use (both legal and illegal drugs)
Eating problems (purging, bingeing, overeating, hoarding, severely restricting food intake)
Excessive behaviors (spending, gambling, shopping, video games, etc…)
Family or step family relationships
Fears or phobias
Anxious (nervous, clingy, fearful, worried, panicky, obsessive compulsive)
Angry or irritable
Guilty or ashamed
Sadness or depression
Suicidal
Health issues
Illegal behaviors
Isolates from family
Learning/academic difficulties
Poor social skills
Making/keeping friends
Poor self-management
- ______ requires constant reminders
- ______ poor time management
- ______ can become defiant
- ______ talks back

Non-family relationships (friend, teacher, etc…)
Personal growth (no specific problem)
Pornography
Religious or spiritual concerns
Self esteem problems
Self-injury behaviors
Sexual behaviors/acting out
Sexual identity concerns
Sleep problems (nightmares, sleeping too much or too little, etc…)
Stress
Homicidal
Behaviors (bizarre actions, speech, compulsions, tics, motor behavior, etc...)
Unusual experiences (loss of periods of time, sensing unreal thoughts, etc…)

**Print**