Samaritan Counseling Center of West Texas, Inc.

Adolescent Client Intake Information

Thank you for choosing Samaritan Counseling Center of West Texas for your care. Please complete the following form entirely. This information will aid your therapist in your care. You may use the back of this form for any additional information you feel is important to communicate. Please fill out a form for each person who will participate in your session.

First Name _____ Middle Initial _____ Last Name _____

Birth Date _____/_____/_____ Age _____ Gender _____M _____F Soc Sec # _____/_____/_____

Address _____ City _____ St. _____ Zip _____

Name of Primary Care Physician _____ Psychiatrist (if applicable) _____

Parent Name (F)_____ (MI) _____ (L) _____ Soc Sec # _____ / _____ / _____

Mailing Address (if different from above) _____ City _____ St. _____ Zip _____

I am client's _____ Mother _____ Father _____ Guardian I am client's Custodial Parent _____ Yes ____ No

I am authorized to seek medical treatment for this client _____ Yes _____No

I have brought court documents as proof of legal standing if this child was part of a legal proceeding _____Yes _____No

(Per Texas State Board of Examiners of Professional Counselors Title 22, Texas Administrative Code Chapter 681 a licensed therapist "shall obtain and review a current copy of the custody agreement or court order as well as any applicable divorce degree" and "shall maintain these documents in the client's record" prior to conducting any therapy services)

Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Which phone number is best to use in order to contact you and leave a message? _____

Please complete the following information required by our grant funding:

Are you a military person: _____ Current Active Duty _____ Veteran ____ Family Member ____ No
If you are, have you or a family member been: _____Previously deployed to Iraq/Afghanistan
_____ Currently deployed to Iraq/Afghanistan

Your Ethnicity: _____ African-American _____ Caucasian _____ Asian ____ Hispanic/Latino(a) _____ Native-American
_____ Other: _____

Annual Household Income $_____ Number living in your household _____

INSURANCE Information – we will need a copy of your current card and ID.
Primary Insurance Co. _____ Member ID# _____ Group #_____
Policy Holder Name _____ Policy Holder Date of Birth ____/____/_____
Policy Holder Social Sec. # _____/_____/_____

Insured or Responsible Party Signature: I consent and I authorize the Samaritan Counseling Center of West Texas to release medical or other supporting information necessary to process my insurance claims and/or for the collection of payment for services from the above person/organization/company. I authorize payments of medical benefits to the Samaritan Counseling Center of West Texas. However, I understand I am responsible for all deductibles and co-pays. I understand that I will be responsible for 100% of my charges should insurance not compensate the Center for my sessions. All charges and co-pays are payable and due at the time of service.

I further testify that I am the custodial parent of this minor and/or have given proof that I can seek therapy for this client.

Printed Name _____ Signature _____Date _____

FAITH/SPIRITUALITY

Samaritan Counseling Center of West Texas is a faith-based organization and we believe that by including the client's faith as a part of the therapeutic process, therapy is enhanced. It is our philosophy to work within the faith framework of the client. The Center's therapists do not impose their personal beliefs upon clients; rather, they honor the client's right to choose their own belief system.

[ ] I chose Samaritan Counseling Center due to its faith-based perspective.

[ ] I would prefer not to complete the section below and do not want my spirituality to be addressed as a part of my discussions in therapy.

If you currently attend worship, which church/synagogue/temple do you attend? _____

How long have you attended there? _____

In your lifetime, how many years have you attended? [ ] 0-2 years [ ] 3-5 years [ ] 6 – 10 years [ ] 6-10 years [ ] Over 10 years

In childhood, did you attend a church/synagogue/temple? [ ] Yes [ ] No

Have you been a part of other denominations in the past? [ ] Yes [ ] No

Please list those denominations: _____

Please check in faith/spiritual concerns you may have:

[ ] Spiritual hunger [ ] Loss of faith [ ] Faith differences with partner/family

[ ] Moral dilemma [ ] Feelings of guilt [ ] Inability to feel forgiveness/forgive

[ ] Religious doubts [ ] Anger at God [ ] Confusion about values

[ ] Painful religious history. Please Explain: _____

Others concerns:_____

Which of the following do you actively participate in or receive support from?

[ ] Personal prayer [ ] Congregational support [ ] Spiritual or Bible reading

[ ] Support from clergy [ ] Spiritual direction [ ] Small groups at church

[ ] Bible Study [ ] Spiritual Disciplines: (please describe) _____

_____

At your request, our therapists can include faith, values and spiritual concerns in the counseling process. Please check the items below that could add value to your therapeutic experience.

[ ] Pray at the beginning of sessions [ ] Pray at the end of sessions

[ ] Use Biblical and/or faith examples [ ] Recommend religious or spiritual readings

[ ] Recommend spiritual growth activities [ ] Share personal faith perspectives when appropriate.

Other ideas for integrating faith into my therapy: _____

_____

Samaritan Counseling Center of West Texas
ADOLESCENT'S PSYCHOSOCIAL HISTORY FORM

(To be utilized with children 11 to 17 years of age)

Date: _____ _____

Child's Name: _____ Person Completing Form: _____

Child's Birthdate: _____/_____/_____ Relationship to Child: _____

Child's Age: _____ Child's grade in school: _____ Child's School: _____

Presenting Concerns:

Why are you bringing your child to therapy? _____

_____

When did you first notice these issues? _____

Have you previously sought help for this problem? Please explain: _____

_____

Please list any physical or psychological stressors in your child's life: _____

_____

Family Structure:

Biological Mother's Name:_____ Biological Father's Name:_____

Address (physical)_____ Address (physical)_____

City_____ State_____ City_____ State_____

Phone Number_____ Phone Number_____

Occupation:_____ Occupation:_____

Biological parents' marital status _____ Currently Married _____ Divorced _____ Separated _____ Never Married

Please describe your child's family structure: (i.e. nuclear family, step-family, single parent home, non-custodial parent absent emotionally from child's life, grandparents living in home, grandparents raising the child, etc.) _____

_____

Siblings (Age, Sex): _____

How do the biological parents relate to one another? _____

Please describe any history of custody disputes or legal actions regarding child:_____

Please describe your approach to parenting: _____

_____

How does your child respond? _____

Is counseling being sought in connection to an ongoing DFPS case? ____ yes ____ no: If yes please explain:_____

_____

Social Worker's name:_____ Phone number:_____

Developmental History:

Pregnancy Complications – Yes ____ No ____; If yes please explain: _____

_____

Delivery Complications – Yes ____ No ____; If yes please explain: _____

_____

Were any of the following issues present during Infancy? Yes ____ No ____ (Feeding problems, Sleeping problems, child did not like to be held, child was not alert, growth & development problems, etc) If Yes please explain.

_____

Were there any developmental delays for your child? Yes ___ No ___ (i.e. walking, talking, sitting up, bladder trained, bowel trained, buttoned clothing, tied shoe laces, road bike/trike, Began to read, etc.) If Yes, explain:

_____

_____

Has your child had any problems with Coordination? Yes ____ No ____ If Yes please explain. _____

_____

Educational History:

Does your child like school? Yes ____ No ____ If No please explain: _____

Has your child's performance in school changed over-time? _____

Grades achieved in the last 6 weeks _____

How does your child relate to his or her teachers at school _____

Does your child have difficulty in a particular subject? Yes ___ No ____ If yes please explain: _____

_____

Does you child receive any special services at school including behavior modification plans?_____

_____

Peer Relationships:

Does your child relate well with peers? Yes ____ No ____ If no please explain _____

_____

Does your child seek and is she/he sought by peers to play with? Yes____ No _____If No please explain: _____

_____

Medical History:

Please check and explain if you child has had any of the following:

Issue:	√	Explain:
Childhood diseases	___	_____
Operations	___	_____
Hospitalizations	___	_____
Head Injuries	___	_____
Convulsions/seizures	___	_____
Vision Problems	___	_____
Hearing Problems	___	_____
Sleep Problems	___	_____
Appetite	___	_____
Abuse	___	_____
Concerns:	___	_____

Is you child receiving services from community support agencies (physical therapy/case management/family educational Services/hospice, etc) in addition to counseling to address these issues?

Agency	Type of therapy provided
_____	_____
_____	_____

Has your child had encounters with Law Enforcement? ___Yes ____No If yes please explain:_____

_____

To the best of your knowledge is your child sexually active? ___Yes ___No If yes please explain:_____

_____

To the best of your knowledge has your child been exposed to bullying or exposure to inappropriate sexual content through the internet or social media? ___Yes ___No If yes please explain:

_____

Please describe your child's access to internet/social media:_____

To the best of your knowledge does you child use illegal substances, alcohol, cigarettes or inhalants? ____Yes ____No

Substance used	First usage	Last use	Current use	Frequency	Amount
Alcohol			Yes No		
Amphetamines/speed			Yes No		
Caffeine			Yes No		
Cocaine			Yes No		
Crack cocaine			Yes No		
Hallucinogens			Yes No		
Inhalants			Yes No		
Marijuana			Yes No		
Nicotine			Yes No		
Prescriptions			Yes No		
Synthetic Marijuana			Yes No		

Please describe any history of bullying or peer pressure:_____

Please describe any history of known cutting, self harm or risk taking behavior:_____

_____

Family Medical Issues: (please include extended family including parents, siblings, half-siblings, grandparents, cousins, uncles, aunts, if adopted biological parents, etc.)

Problem: √ **Relationship to Child** **Description of Problem**

Alcoholism ___ _____ _____

Drug Abuse ___ _____ _____

Psychological ___ _____ _____

Anger Issues ___ _____ _____

Suicides ___ _____ _____

Abuse ___ _____ _____

Medicines Your Child Is Taking:

	Psychiatric Medications	Dosage	Times/Day	Condition	Physician
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Other Medications: Please list and explain: _____

How much "of the time" does your child experience the following behaviors?

Strengths -	Never	Some	A Lot	Almost All
Makes friends easily				
Handles changes easily				
Self-motivated				
Has a variety of interests				
Expresses thoughts and feelings verbally				
Understands what people tell him or her				
Motor coordination is developmentally appropriate				
Stays seated when asked				
Can keep quiet when necessary				
Finishes a task before moving to another				
Rarely misses school				
Respects people's property				
Is appropriate with treatment of animals				
Handles anger appropriately				
Sleeps in their own room				
Is carefree with few worries				
Maintains a healthy weight				
Seems content to be a boy/girl				
Sleeps easily and through the night				
Sees doctor for check-ups (1 time year)				
Has age appropriate ideas about sex				

In Need of Improvement -	Never	Some	A Lot	Almost All
Lacks awareness of feelings				
Does not seek comfort when stressed				
Lacks social play/interaction				
Is easily distracted				
Has difficulty paying attention				
Loses things				
Talks excessively				
Runs away from home				
Lies				
Has deliberately started fires				
Has stolen				
Has been cruel to animals				
Starts physical fights				
Has used a weapon in a fight				
Often loses temper				
Argues with adults inappropriately				
Deliberately annoys others				
Blames others when in trouble				
Worries about family members				
Avoids being alone				
Has distress when parents leave				
Is self-conscious				
Has trouble in school/grades				
Needs lots of reassurance				
Has sudden involuntary motor movements/tics				
Wets the bed and or has accidents during the day				
Seems depressed and sad				
Has physical complaints				
Has less energy than other children their age				
Sleeps too much				
Has nightmares; abrupt awakenings, or sleepwalks				
thinks weird odd strange things				
Hears voices				

Additional Comments: _____

_____

_____

_____