

The Biblical Counseling Center

INTAKE FORM - ADOLESCENT

PERSONAL INFORMATION

Name _____ E-mail _____

Street Address _____

City _____ State _____ Zip _____

Gender: (M F) Birth Date _____ Age _____ Weight _____ Height _____

Home Phone _____ Cell Phone _____ Grade in School _____

Have you ever been held back in school? Yes No; If yes what grade? _____

Do you work any where? Yes No; If yes where? _____

I was referred to The Biblical Counseling Center by _____

FAMILY INFORMATION

Mother's Name _____ Father's Name _____

Do you live with both of your parents? Yes No; If not who? _____

Do you have a step parent? Yes No; If yes what is their name? _____

Were you raised by anyone other than your own parents? Yes No If "yes," please explain:

How many older siblings do you have? _____ Brothers _____ Sisters _____

How many younger siblings do you have? _____ Brothers _____ Sisters _____

RELIGIOUS BACKGROUND

When you attend church where do you go? _____

Are you a member? Yes No Denominational Preference _____

Church Address _____

Pastor's Name _____ Pastor's Phone _____

May we contact your pastor for information and help? Yes No

Church attendance per month (**circle one**) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩+

Do you consider yourself to be a religious person? Yes No Uncertain

Do you believe in God? Yes No Uncertain

Do you pray to God? Yes No Uncertain

Have you been baptized? Yes No; If yes when? _____

How do you characterize your relationship to Jesus? None Struggling Strong

How often do you read the Bible? Never Seldom Often

Describe any recent changes in your spiritual life _____

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If something happened to you, would you go to heaven? Yes No; If you checked yes, how do you know that you would go to heaven? _____

PERSONALITY INFORMATION

Have you been to a biblical counselor before? Yes No; If yes, when? _____

Have you had any psychotherapy before? Yes No: If yes, fill in below:

Counselor's Name	Dates (Month & Year)	Medication Prescribed	Diagnosis Outcome
	From To		
	From To		
	From To		

Please check any of the following words that would describe you:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Ambivalent | <input type="checkbox"/> Self-confident | <input type="checkbox"/> Persistent |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Hardworking | <input type="checkbox"/> Impatient |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Moody | <input type="checkbox"/> Active |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Excitable | <input type="checkbox"/> Imaginative |
| <input type="checkbox"/> Often-blue | <input type="checkbox"/> Serious | <input type="checkbox"/> Serious |
| <input type="checkbox"/> Calm | <input type="checkbox"/> Shy | <input type="checkbox"/> Good-natured |
| <input type="checkbox"/> Easy-going | <input type="checkbox"/> Extrovert | <input type="checkbox"/> Likeable |
| <input type="checkbox"/> Introvert | <input type="checkbox"/> Quiet | <input type="checkbox"/> Hard-boiled |
| <input type="checkbox"/> Leader | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Hypersensitive |
| <input type="checkbox"/> Submissive | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Suspicious | | |

Please check the appropriate response:

- | | | |
|---|------------------------------|-----------------------------|
| Have you ever felt people were watching you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had hallucinations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you sometimes unable to judge distances? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you afraid of being in a car or airplane? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your hearing exceptionally good? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Approximately how many hours sleep do you get each night?

When do you usually: Go to sleep? _____ Fall asleep? _____ Get out of bed? _____

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HEALTH INFORMATION

Rate your health: Excellent Good Average Declining Other

Describe any recent weight changes? _____

List all important present or past illnesses, injuries and handicaps _____

Do the above limit you in any way? Yes No; If Yes, how? _____

Date of last medical exam: _____ Report: _____

Your physician _____ Address _____

Are you presently taking medication? Yes No; If yes, what? _____

Have you used drugs or alcohol for other than medical purposes? Yes No

If "yes," when and what did you use? _____

Have you ever had a severe emotional upset? Yes No; If yes, please describe briefly:

Have you ever been arrested? Yes No; If yes, describe outcome?

ANSWER THESE QUESTIONS

1. What is the main thing that is bothering you right now?

2. Have you been able to do anything about it? Explain;

3. What do you want to happen as you receive biblical counseling?

4. Who do you consider a friend (or a family member) who has talked with you about what you are going through? _____ Why?

5. Is there any other information that you think we should know that we could better help you?