BIBLICAL COUNSELING CENTER OF ROCHESTER

Consent for Counseling of Minors / Adolescents / Teenagers
(Parental permission required to age 18)

Name of Parent/Guardian:_____

Name of Minor_____

Minor's Date of Birth:_____

This is to certify that I give permission to Biblical Counseling Center of Rochester for treatment of my child.
A parent or legal guardian must remain present and available in the building at all times during counseling sessions.
This counseling may include individual or family counseling. This counseling may include consultations with other associates of this institution.
This counseling may also include referrals to a family physician, or other appropriate agency, for further consultation, if necessary.

In signing this I agree not to call my counselor into court and I give up my right to subpoena any records or notes.
The counselors of the BCCR are here to spiritually help you and your family. We will not aid you in any legal actions at all.
I have read the conditions for counseling and understand them. I have honestly answered all of the questions herein.

Signature of Parent/Guardian_____ Date_____

Printed name _____

Street Address_____

City/State/Zip_____

Home Phone_____ Work Phone_____

REASONS FOR SEEKING HELP

What concerns about your child have brought you to counseling today?
_____

_____

What effect does your child's problems have on you? _____

_____

Where are these concerns causing the most problems for your CHILD? Please check all that apply.

□ Home □ School □ Friends □ Other:_____

When did the present concerns begin to be a problem for your child?_____

What concerns about the child have been identified by others?_____

Please indicate which of the following areas are currently problems with the child. Check all that apply.

□ Crying Spells	□ Hyperactivity
□ Excessive fears or anxieties	□ Bullying/picking fights
□ Difficulty being away from specific family members	□ Refusal to respond to authority
□ Hearing Voices	□ Nightmares
□ Getting into trouble at school	□ Obsessions/compulsion with specific activities
□ Temper Tantrums	□ Lack of Motivation
□ Difficulty Falling Asleep/inability to sleep at night	□ Lack of self confidence
□ Decreased/increased Appetite	□ Difficulty making/keeping friends
□ Loss of interest in usual activities	□ Other:_____

What do you hope to gain from counseling? _____

_____

How did you hear about our counseling service? _____

General Information

The child is currently living with: _____

School _____ Grade_____

Extracurricular activities/interests:_____

Is alcohol consumed in the house? Yes ____ No ____ Drugs? Yes ____ No ____

Medical History

How would you rate your child's current physical health? □ Excellent □ Good □ Fair □ Poor

Date of last physical _____

Is the child currently complaining of any physical problems (e.g. headaches, stomach aches) □ Yes □ No

If yes, please explain:_____

Previous hospitalizations for medical reasons Date:_____ Reason:_____

Date:_____ Reason:_____

Please list any medical conditions or disabilities:_____

Please list any learning disabilities:_____

Medications Over the counter or prescription	Dosage

Counseling and Psychiatric History

Has the child had any previous counseling? □ Yes □ No If yes, when?_____ For how long?_____

For what reason?_____

Has the child ever been diagnosed with or treated for any type of mental illness? □Yes □No If yes, which type?_____

_____

Has anyone in the child's family ever been diagnosed with or treated for mental illness? □Yes □ No If yes, which type?_____

Psychiatric Medication(s)	Dosage

Parent/Guardian Information:

Marital Status: □ S □ M □ D □ W Date of Current Marriage/Separation:_____ # of Marriages____

Sibling's Name(s) _____ Date of Birth: _____□ M □ F

_____ Date of Birth: _____□ M □ F

_____ Date of Birth: _____□ M □ F

Occupation:_____ Highest level of education_____

Name of other custodial parent:_____ Phone:_____

Do you have consent from the other custodial parent for treatment of your child?_____
If no, is this required before counseling may begin. Yes ____ No ____

How much contact per month does the child have with his biological mother/father?_____

What is your religious preference?_____

Are you a member of a church?_____ If yes, what church?_____

Has your child received Christ into their life as Savior (saved, born again)? Yes ____ No ____

TEENAGERS: Please fill out the following yourself

Employment _____

Please rate each issue with a number: 1=Major Problem 2=Sometimes a Problem 3=Never a Problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Feeling bad about the way I look/body image

_____ Getting along with my parents or other family members

_____ Getting a clear sense of what I value

_____ Worrying about whether I am normal

_____ Dealing with sexual feelings and/or problems

_____ Excessive worry or anxiety

_____ Trying to decide on a career

_____ Never eating/eating too much and vomiting to control weight

_____ Dealing with my alcohol or drug abuse

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

Are there any other problems or concerns you would like to address?_____

_____