LIGHTHOUSE
CHRISTIAN COUNSELING
Light for Hope

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Confidential Intake for Minors

Please have your child or adolescent fill out as much as they are able. Fill out completely for younger children.

Name: _____ Date: _____ DOB: _____

Home Address: _____ Sex: Male ❑ Female ❑

City, State, Zip: _____ School: _____

Home Phone: (_____) _____ - _____ Grade: _____

Cell Phone: (_____) _____ - _____ SS #: _____

Email: _____

May we call you at: Home: Yes ❑ No ❑ Cell: Yes ❑ No ❑

May we send mail to you at your home address? Yes ❑ No ❑

Do you have any hobbies?
_____

Job: _____

Health Insurance Information

Insured Name: _____ SS#: _____ -_____ - _____
DOB: ____/ ____/ _____

Insurance Company: _____ Group#: _____

ID#: _____

Address: _____

City, State, Zip: _____

Benefits / Eligibility Phone #: (_____) _____ - _____

Insured Employer: _____

Employer's Address: _____

City, State, Zip: _____

Health & Personal Information

Would you describe your current physical health as: Excellent ❑ Good ❑ Fair ❑ Poor ❑

How many hours do you sleep each night? _____

Do you currently have any physical problems? Yes ❑ No ❑ If yes, please explain:

_____

_____

Are religious or spiritual issues important to you? Yes ❑ No ❑

How much do they impact/influence your daily life?
A great deal ❑ A reasonable amount ❑ Some ❑ Very little ❑

Do you currently attend church? Yes ❑ No ❑

If yes, where do you attend?

_____

Problems you would like to talk about?

_____

_____

_____

How often are you troubled by these concerns?

Constantly ❑ Often ❑ Sometimes ❑ Not very often ❑

Have you ever been admitted as inpatient or outpatient in a hospital for mental health issues?
Yes ❑ No ❑

If yes, please give issue, dates and hospital:
_____

Please indicate your current level of the following symptoms or behaviors:

	Never	Rarely	Sometimes	Frequently
Dealing with problems at school:	❑	❑	❑	❑
Feeling angry or having outbursts:	❑	❑	❑	❑
Dealing with my use of alcohol or drugs:	❑	❑	❑	❑
Trouble concentrating/ easily distracted:	❑	❑	❑	❑
Feeling accepted by my peers:	❑	❑	❑	❑
Dealing with how I feel about myself:	❑	❑	❑	❑
Eating too much/ too little	❑	❑	❑	❑
Wanting to sleep all the time:	❑	❑	❑	❑
Excessive recurring thoughts:	❑	❑	❑	❑
Lack of interest/ motivation in activities:	❑	❑	❑	❑

	Never	Rarely	Sometimes	Frequently
Getting into trouble at school/work:	❑	❑	❑	❑
Out of control / controlling myself:	❑	❑	❑	❑
Dealing with sexual feelings/ problems	❑	❑	❑	❑
Dealing with peer pressures:	❑	❑	❑	❑
Feeling of stress, under too much pressure:	❑	❑	❑	❑
I want to hurt someone:	❑	❑	❑	❑
Feeling bad about myself/how I look:	❑	❑	❑	❑
Mood shifts:	❑	❑	❑	❑
Trouble making or keeping friends:	❑	❑	❑	❑
Trying to decide about college/career:	❑	❑	❑	❑
Getting along with my parents/ family members:	❑	❑	❑	❑
Being obedient to parents:	❑	❑	❑	❑
Teacher / School reports on behavior:	❑	❑	❑	❑

Signature of Minor:

_____

Signature of Parent/Guardian:

_____