



## **Counseling Application for Minors**

Please complete this application carefully.

### **Personal Identification**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Referred By: \_\_\_\_\_

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Employer (if you work): \_\_\_\_\_ Position: \_\_\_\_\_

Number of hours worked per week: \_\_\_\_\_ How long have you been working: \_\_\_\_\_

### **Family**

Father: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long employed: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long employed: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Have either of your parents been previously married: \_\_\_\_\_ Father \_\_\_\_\_ Mother

Have your parents ever separated: \_\_\_\_\_ Father \_\_\_\_\_ Mother

Have either of your parents ever filed for divorce: \_\_\_\_\_ Father \_\_\_\_\_ Mother

Describe your relationship to your father: \_\_\_\_\_

\_\_\_\_\_

Describe your relationship to your mother: \_\_\_\_\_

\_\_\_\_\_

Number of sibling(s): \_\_\_\_\_ Your sibling order: \_\_\_\_\_

Did you live or have you lived with anyone other than parents: \_\_\_\_\_

\_\_\_\_\_

Are your parents living: \_\_\_\_\_ Father \_\_\_\_\_ Mother

**Health**

Describe your health:

\_\_\_\_\_

Do you have any chronic conditions: \_\_\_\_\_ What: \_\_\_\_\_

List important illnesses and injuries or handicaps:

\_\_\_\_\_

\_\_\_\_\_

Date of last medical exam: \_\_\_\_\_ Report: \_\_\_\_\_

Physician's name and contact information:

\_\_\_\_\_

Current medication(s) and dosage:

\_\_\_\_\_

\_\_\_\_\_

Have you ever used drugs for anything other than medical purposes: \_\_\_\_\_

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Have you ever been arrested: \_\_\_\_\_

Do you drink alcoholic beverages: \_\_\_\_\_ If so, how frequently and how much: \_\_\_\_\_

\_\_\_\_\_

Do you drink coffee: \_\_\_\_\_ How much: \_\_\_\_\_ Other caffeine drinks: \_\_\_\_\_

\_\_\_\_\_ How much: \_\_\_\_\_

Do you smoke cigarettes or use tobacco products: \_\_\_\_\_ Frequency: \_\_\_\_\_

Have you ever had interpersonal problems at school: \_\_\_\_\_ If yes, please explain:

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Have you ever had a severe emotional upset: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

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Have you ever seen a psychiatrist or counselor: \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

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Are your parents willing to sign a release of information form so that your counselor may write for social, psychiatric, or other medical records: \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Spiritual**

Denominational preference: \_\_\_\_\_

Church attending: \_\_\_\_\_ Member: \_\_\_\_\_

Sunday School class/teacher (if FBC Jax member): \_\_\_\_\_

Church attendance per month (circle): 0 1 2 3 4 5 6 7 8+

Do you believe in God: \_\_\_ Do you pray: \_\_\_ Would you say you are a Christian: \_\_\_\_\_,  
or still in the process of becoming a Christian: \_\_\_\_\_

Have you ever been baptized: \_\_\_\_\_

How often do you read the Bible: Never: \_\_\_ Occasionally: \_\_\_ Often: \_\_\_ Daily: \_\_\_\_\_

Explain any recent changes in your religious life:

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### **Women Only**

Have you had any menstrual difficulties: \_\_\_\_\_ If you experience tension, tendency  
to cry, other symptoms prior to your cycle, please explain: \_\_\_\_\_

**Problem Check List**

- |                           |                       |                         |
|---------------------------|-----------------------|-------------------------|
| _____ Anger               | _____ Drunkenness     | _____ Loss of Loved One |
| _____ Anxiety             | _____ Eating problems | _____ Lust              |
| _____ Apathy              | _____ Envy            | _____ Memory            |
| _____ Appetite            | _____ Fear            | _____ Moodiness         |
| _____ Bitterness          | _____ Finances        | _____ Perfectionism     |
| _____ Change in lifestyle | _____ Gluttony        | _____ Pornography       |
| _____ Children            | _____ Guilt           | _____ Rebellion         |
| _____ Communication       | _____ Health          | _____ Sex               |
| _____ Conflict (fights)   | _____ Homosexuality   | _____ Sleep             |
| _____ Deception           | _____ Impotence       | _____ Spousal Abuse     |
| _____ Decision Making     | _____ In-laws         | _____ A Vice            |
| _____ Depression          | _____ Loneliness      | _____ Other             |

**INFORMATION**

We are grateful to the LORD for the opportunity to meet with you and sincerely desire to understand what is happening in your life. The below questions are a way for us to gather more information about what is going on. Your answers can be as long as you like but please write at least a few sentences for each question. **(If additional space is needed, please feel free to answer the questions in a separate document.)** Thank you for your help, and we will be prayerfully anticipating our meeting.

*Situation:* What is the main problem?

*Thinking:* What do you think or wonder about yourself in relation to the situation?  
What do you think of others in relation to the situation?

*Others:* How are others involved? How does this issue impact others? What have others done to compound or alleviate the problem?

*Response:* What are you doing about this issue? What have you done to try to address this issue in the past? What are your typical actions or reactions to this problem (e.g. “I get angry and go for a drive”)? In general, when you are feeling pressure in life, how does it come out? What do you do? How are you sleeping?

*Emotions:* What do you fear? What would give you peace, related to this situation? What is the emotion you are struggling with the most?

*Desires/Expectations:* How do you hope we can help you? What do you want the most related to this situation?

Is there anything else we should know?