soulCare
a biblical counseling ministry of Calvary Baptist Church

SoulCare Request for Children & Adolescents (Under 18)

Date: _____

Welcome to SoulCare! Please complete with as much detail as you feel comfortable sharing. Be assured that this information will only be viewed by the counselor and appropriate SoulCare leadership.

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Sex: ____

Grade in School: _____ Name of School (or indicate if homeschooled)_____

Form completed by (if someone other than the child/teen) _____

Relationship of that person to child/teen: _____ Phone: _____

Guardian's Mailing Address: _____

City _____ State _____ Zip Code: _____

Mother's Name: _____ Phone: _____

Father's name: _____ Phone: _____

Parent's Email Address: _____

Preferred Method of Contact (Consider Confidentiality): _____

Emergency Contact Name: _____Phone: _____

Relationship of emergency contact to child/teen:_____

Who referred you or how did you hear about SoulCare? _____

Is the child/teen coming to counseling voluntarily? ___ Yes ___ No

FAMILY INFORMATION

With whom does the child/teen live at this time (name of person):_____

Relationship to the child/teen (stepmom/dad, adopted parent, etc):_____

Are parents divorced? ___ Yes ___ No Separated? ___ Yes ___ No If divorced, who has legal custody? _____

Brothers/Sisters Names Age Gender Relationship to child/teen (good/fair/poor) Living w child/teen (Y/N)

_____

_____

_____

_____

List any significant information about the parent(s) or guardian(s) relationship or treatment toward the child/teen which might be beneficial to counseling _____

_____

List any significant information and/or events in the family which might be beneficial for counseling: _____

_____

_____

REASON FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

What areas of the child/teen's life are being most affected by this issue? (***Check all that apply):***

___ Home ___ School ___ Friends ___ Other Relationships ___ Relationship with God ___ Other: _____

When did the present concern begin to be a problem? _____

Were there any significant events occurring in his/her life/family when this issue began? _____

_____

Has the child/teen ever gone to a counselor? ___ Yes ___ No If yes, was it a Christian counselor? ___ Yes ____ No

How do you feel about the results of the previous counseling? ___ Dissatisfied ___ Somewhat satisfied ___ Very satisfied

What do you hope to gain from SoulCare? _____

Please rate the severity of your present concerns on the following scale ***(Check one):***

___ Mild ___ Moderate ___ Severe ___ Totally incapacitating

Have the child/teen answer the following questions:

What really hurts me is _____

What I want most in life is _____

What I fear most in life is _____

My biggest regret is _____

To be really happy, I need _____

I would do anything for _____

Are you taking prescription meds as prescribed by a doctor? ___ Yes ___ No

CHILD/TEEN'S MEDICAL/HEALTH INFORMATION

Rate the child/teen's overall health **(*Check one*):**

___ Excellent ___ Good ___ Average/Fair ___ Poor ___ Other

Have there been any significant weight changes in the past year? ___ Yes ___ No

List any major present or past illnesses, injuries or disabilities: _____

_____

List any major surgeries/medical hospitalization: _____

_____

List any delays in development (speech, motor, etc.): _____

Date of last examination: _____ Physician's name:_____

Is he/she presently taking any psychiatric medication? ___ Yes ___ No

If so, for what purpose? _____

Has he/she been previously hospitalized or received treatment for psychiatric reasons? ___ Yes ___ No

If so, for what purpose? _____

List any prescribed and over-the-counter meds taken regularly _____

CHILD/TEEN'S RELATIONSHIP WITH GOD AND CHURCH

Does he/she attend Calvary? ___ Yes ___ No If so, what does he/she attend? **(*Check all that apply):***

___ Sunday worship services ___ Sunday School ___ Youth Group ___ Other _____

Does he/she attend another church or youth group? ___ Yes ___ No If yes, name of church:_____

Is he/she trusting in Jesus and His death and resurrection on the cross for salvation? ___ Yes ___ No ___ Not sure

Please describe how his/her relationship with Jesus Christ began and any significant changes to his/her spiritual life:

_____

_____

How would the child/teen describe God's view of him/her (Does God care? Is He near? Far? Disappointed? Angry?...)

_____

_____

CHILD/TEEN'S EMOTIONAL/BEHAVIORAL INFORMATION

Is he/she experiencing abuse now? ___ Yes ___ No Has he/she experienced abuse in the past? ___ Yes ___ No

Does he/she ever feel suicidal? ___ No ___Yes (sometimes) ___ Yes (past attempt) ___ Yes (Has an active plan)

Does he/she feel depressed? ___ No ___ Mildly ___ Moderately ___ Severely

Does he/she feel anxious? ___ No ___ Mildly ___ Moderately ___ Severely

Does he/she feel overwhelmed? ___ No ___ Mildly ___ Moderately ___ Severely

Does he/she now or has he/she ever cut or harmed himself/herself? ___ Yes ___ No

Please provide additional details to any of the above: _____

_____

_____

Does he/she ever use drugs? ___ Yes ___ No Alcohol? ___ Yes ___ No

If yes, drug/alcohol of choice: _____

Please list any addictive-type behaviors: _____

(Ex: drugs, alcohol, food, exercise, sex, pornography, video gaming/internet/cyber, shopping, television, etc.)

Please check how often the following thoughts or experiences occur:

Life is hopeless.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I am lonely.	___ Never	___ Rarely	___ Sometimes	___ Frequently
No one cares about me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I am a failure.	___ Never	___ Rarely	___ Sometimes	___ Frequently
Most people do not like me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I want to die.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I want to hurt someone.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I am stupid.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I am going crazy.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I cannot concentrate	___ Never	___ Rarely	___ Sometimes	___ Frequently
I am depressed.	___ Never	___ Rarely	___ Sometimes	___ Frequently
God is disappointed in me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I cannot be forgiven.	___ Never	___ Rarely	___ Sometimes	___ Frequently
Why am I so different?	___ Never	___ Rarely	___ Sometimes	___ Frequently
I cannot do anything right.	___ Never	___ Rarely	___ Sometimes	___ Frequently
People hear my thoughts.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I have emotional numbness.	___ Never	___ Rarely	___ Sometimes	___ Frequently
I am out of control	___ Never	___ Rarely	___ Sometimes	___ Frequently

Please comment about each of the above thoughts that occur frequently or are a concern to you:

_____

_____

_____

Please indicate which of the following areas currently are problems for the child/teen. **(*Check all that apply)*:**

___ Angry feelings/outbursts
___ Being bullied
___ Excessive fear of specific places/objects
___ Difficulty making friends
___ Feeling as if you would be better off dead
___ Feeling that people are out to get you
___ Delusions
___ Crying episodes
___ Loss of interest in usual activities
___ Obsessions/compulsions with specific activities
___ Feeling trapped in rooms/buildings
___ Visual hallucinations
___ Excessive feelings of guilt/shame
___ Feeling manipulated or controlled by others
___ Insomnia (no sleep) or hypersomnia (sleep all the time)
___ Other: _____

___ Difficulty making decisions
___ Feeling like you aren't good or smart enough
___ Feeling sexually attracted to the same sex
___ Concerns about physical health
___ Blackouts or temporary loss of memory
___ Loss of appetite/increased appetite
___ Issues with food and/or weight
___ Feeling distant from God
___ Nightmares
___ Lack of motivation
___ Inability to control thoughts
___ Hearing voices
___ Lack of energy
___ Feeling worthless
___ Issues concerning gender identity

SETTING UP AN APPOINTMENT

Please check *ALL* possible times you are available to meet for counseling.

(Sessions are 45 minutes long)

	9 am	10 am	11 am	Noon	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm
Mondays												
Tuesdays												
Wednesday												
Thursdays												
Fridays												

ONCE YOU HAVE COMPLETED THIS FORM, PLEASE place it in an envelope and either

1. Drop the form off at the church office or place in Pastor Paul Wilson's church mailbox in the office hallway

   OR

2. Use the online form at *calvarybaptistpa.org*, then save as a PDF and attach it to an email to Pastor Paul at *pwilson@calvarybaptistpa.org*

   OR

3. Mail it to:
   Pastor Paul Wilson
   Calvary Baptist Church
   5300 Green Pond Rd.
   Easton PA 18045

Pastor Paul and/or a counselor will contact you as soon as they are able, to discuss when counseling can begin. If you have any questions, please feel free to call the church office at 610.365.5300.