BIBLICALLY CENTERED COUNSELING

DR. DONALD MACKENZIE

INITIAL PAPERWORK PACKET – MINOR (AGES 4-13)

INSTRUCTIONS FOR YOUR FIRST APPOINTMENT:

1. Print this information packet and complete all aspects before your appointment date. Please bring the completed packet with you to your first appointment. *For children from divorced parents, the initials and signature of the child's non-custodial parent are also required unless parental rights have been terminated. Copies of any legal custody agreements must be delivered prior to the first counseling appointment if parent[s] can be contacted.*

2. Please use blue or black ink when completing these forms. Also, please provide detailed answers to each question on the form.

3. If you are taking any prescription medication(s), please do not alter your dose near your appointment date. If possible, allow two (2) weeks to adjust to any medication before your appointment date.

4. Office hours vary for appointments. Counseling appointments will require approximately one hour in the office. Bathroom facilities are available and childcare is not provided (though a side room is available next to the office).

5. If you have to cancel, please contact me at least 24 - 48 hours ahead of your appointment time.

6. Please see page 7 for confidentiality and privacy information.

Mount Joy Office 717 492 4422

DATE: _____

PERSONAL DATA INVENTORY - Minor

Biological Parent Information:

Parents' Names:_____ Age Male: _____ Age Female: _____

Custodial Parent Address: _____ City/State: _____ Zip: _____

Please provide at least two (2) phone numbers:

Home: _____ Cell: _____ Work: _____

E-mail Address: _____

Mother Occupation / Employer: _____ Father Occupation / Employer _____

Mother Education (last year completed):_____Father Education (last year completed):_____

Parents' Marital Status:

- o Married
- o Separated
- o Divorced
- o Widowed

Child primarily resides with (check all that apply – also, please print the name of the person with whom the child resides):

- o Mother
- o Father
- o Step-parent _____
- o Parent's boy/girlfriend_____
- o Grandfather_____
- o Grandmother_____
- o Uncle _____
- o Aunt _____
- o Adopted parents

Other: _____

Child in Counseling:

Name: _____ Age: _____

Nickname: _____

Grade: _____ School: _____ Guidance Counselor: _____

Is your child coming to counseling voluntarily? Yes ( ) No ( ) Uncertain ( )

Has your child ever lived outside the home? Yes ( ) No ( ) When? _____

Please Explain: _____

_____

Brothers / Sisters	Age	Gender	Living Yes/No	Married Yes/No	PM/A*

** Check this column if child is by previous marriage or adoption.*

HEALTH INFORMATION

State of child's health: Very Good ( ) Good ( ) Average ( ) Declining ( ) Other: _____

Weight Changes recently: Lost _____lbs. Gained _____lbs.

Date of last medical examination: _____ Results: _____

Is the child presently taking any medication? Yes ( ) No ( ) Prescribing Doctor(s): _____

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED FOR…	DATE PRESCRIBED

** Use another page if necessary*

Has the child used drugs for other than medical purposes? Yes ( ) No ( ) What/When? _____

_____

Has the child drunk alcoholic beverages? Yes ( ) No ( ) How often / much? _____

Has the child had counseling, psychotherapy, or seen a psychiatrist before? Yes ( ) No ( )

Age	Duration	Counselor / Center	Issue/Topics/Diagnosis	Evaluation/Result

** Use back of this page if necessary or if you have seen more than three counselors*

Approximately how many hours of sleep does the child average each night? _____

When does your child normally: go to bed? _____ fall asleep?_____ wake up?_____ get out of bed?_____

What does your child normally do between going to bed and falling asleep? _____

Describe any recent changes in sleep habits: _____

_____

Has your child ever complained of or exhibited the following:

Felt people were watching him / her or out to get him / her?	Yes	No	Afraid of being in a car, bathroom, other places, school, etc? _____	Yes	No
People's faces ever seem distorted?	Yes	No	Hearing exceptionally good?	Yes	No
Difficulty distinguishing faces?	Yes	No	Bedwetting or daytime wetting?	Yes	No
Colors ever seem too bright?	Yes	No	Bruises that cannot be explained?	Yes	No
Colors ever seem too dull?	Yes	No	Sexually provocative behaviors?	Yes	No
Unable to judge distance?	Yes	No	Touching their private parts frequently?	Yes	No
Audio (hearing things) or visual (seeing things) hallucinations?	Yes	No			

PERSONAL INFORMATION

Check any of the following words which best describe **your child** *at this time.*

___Active	___Impatient	___Calm	___Outgoing	___Lonely
___Ambitious	___Impulsive	___Serious	___Likable	___ Shy
___Angry	___Moody	___Easy-going	___Leader	___Sensitive
___Persistent	___Often Blue	___Self-conscious	___Follower	___Optimistic
___Nervous	___Excitable	___Self-Confident	___Imaginative	___Pessimistic

Check any of the following struggles or difficulties that **your child** is experiencing *at this time.*

○ Abuse (present)	○ Communication	○ Lifestyle change	○ Self-Injury
○ Abuse (past)	○ Conflict Resolution	○ Memory Loss	○ Step-Family Issues
○ Addiction	○ Depression	○ Moodiness	○ Suicidal Thinking
○ Anger	○ Eating / Food Issues	○ Obsessions / Compulsions	○ Time Management
○ Anxiety	○ Envy	○ Panic Attacks	○ Trust
○ Apathy	○ Fear	○ Peer Issues	○ Work Issues
○ Bad Memories	○ Financial Management	○ People Pleasing	○ Other _____
○ Bitterness	○ Grief	○ Pornography	○ Other _____
○ Chronic Pain	○ Guilt	○ Procrastination	○ Other _____
○ Co-Dependecy	○ Homosexuality	○ Purpose	○ Other _____

Please ask your child to finish these statements:

What really hurts me is_____

What I wish I could change about myself is_____

My childhood was _____

My father is/was _____

My mother is/was_____

My biggest regret is _____

For refuge/rest I turn to _____

To be happy I need _____

I would do anything for _____

If your child was reared by anyone other than his / her parents, please briefly explain: _____

_____

How many older siblings does your child have? Brothers _____ Sisters _____

How many younger siblings does your child have? Brothers _____ Sisters _____

Any major changes in the family during the last year (i.e. death, sickness, move, divorce) Yes No

Explain _____

PARENTAL INFORMATION

Biological Mother (If the mother is absent, you may describe the child's primary female role model – i.e. step-mother, grandmother, etc.)**: If other female role-model, please state role: _____**

Check any of the following words which best describe **the child's mother**.

___Active	___Impatient	___Calm	___Outgoing	___Lonely
___Ambitious	___Impulsive	___Serious	___Likable	___ Shy
___Angry	___Moody	___Easy-going	___Leader	___Sensitive
___Persistent	___Often Blue	___Self-Conscious	___Follower	___Optimistic
___Nervous	___Excitable	___Self-Confident	___Imaginative	___Pessimistic

Has the child's mother ever been diagnosed with a mental health disorder? Yes ( ) No ( )

What/When? _____ Taking medication? Yes ( ) No ( )

Does the mother drink alcoholic beverages or use/abuse drugs? Yes ( ) No ( ) In Past ( ) How often / much? _____ When? _____

Approximately how many hours of sleep does the mother average each night? _____

Please describe methods of discipline used by the mother. _____

_____

Please describe the relationship between the child and biological mother. _____

_____

Biological Father (If the father is absent, you may describe the child's primary male role model – ie. step-father, grandfather, etc.)**: If other male role-model, please state role: _____**

Check any of the following words which best describe **the child's father**.

___Active	___Impatient	___Calm	___Outgoing	___Lonely
___Ambitious	___Impulsive	___Serious	___Likable	___ Shy
___Angry	___Moody	___Easy-going	___Leader	___Sensitive
___Persistent	___Often Blue	___Self-conscious	___Follower	___Optimistic
___Nervous	___Excitable	___Self-Confident	___Imaginative	___Pessimistic

Has the child's father ever been diagnosed with a mental health disorder? Yes ( ) No ( )

What/When? _____ Taking medication? Yes ( ) No ( )

Does the father drink alcoholic beverages or use/abuse drugs? Yes ( ) No ( ) In Past ( ) When?_____
How often / much? _____

Approximately how many hours of sleep does the father average each night? _____

Please describe methods of discipline used by the father: _____

_____

Please describe the relationship between the child and biological father: _____

SPIRITUAL / RELIGIOUS INFORMATION

Primary Caregiver / Parent:

DO YOU CONSIDER YOURSELF A RELIGIOUS PERSON? Yes ( ) No ( )
Do you attend church? Yes ( ) No ( ) Denominational Preference: _____

If yes, Church Name: _____Church Attendance/Activities: _____ times / month

Please list any ministry involvement: _____

DO YOU BELIEVE IN GOD? Yes ( ) No ( ) Not Sure ( )

DO YOU PRAY TO GOD? Never ( ) Occasionally ( ) Often ( )

What do you pray about? _____

ARE YOU SAVED? Yes ( ) No ( ) Uncertain ( )

Do you read the Bible? Never ( ) Occasionally ( ) Often ( )

Do you have personal devotions? Never ( ) Occasionally ( ) Often ( )

Please note any recent changes in your spiritual life: _____
_____
_____

Please complete the following in one or two sentences:

1. Please describe the reasons for coming to counseling. _____
_____
_____

2. Other than counseling, what help are you seeking? _____
_____

3. What are your expectations in coming here? _____
_____

4. What, if any are your concerns about coming to counseling? _____
_____

5. Please list and describe key *positive* peer relationships in your child's life._____
_____

6. Please list and describe key *negative* peer relationships in your child's life._____
_____
_____

7. Is there any other information we should know? _____

Biblically Centered Counseling

Instructions for Policy Review: *Please read each of the policies on the following three (3) pages. After reading each policy please place your initials in the space provided to indicate your understanding and agreement with the stated policy.* For children of divorce, the initials and signature of the child's non-custodial parent are also required unless parental rights have been terminated. *If you have any questions please direct them to your counselor prior to your initial meeting. If for any reason you are unable to sign these forms, counseling services will not be available to you.*

FINANCIAL POLICY

Biblically Centered Counseling provides counseling services on a fee for service basis. Therefore, it is the responsibility of each client to cover the costs for their counseling. The regular fee is $70.00 per 55-minute session. Fees for counseling services are expected at each session. There is a $25 charge for returned checks.

** Initial here if you understand and agree to adhere with this Financial Policy: _____ _____

APPOINTMENT CANCELLATION POLICY

We require a 24 hour notice if you wish to cancel or are unable to keep an appointment (48 hours preferred). Email is not an acceptable form of contact. If you fail to give us a 24 hour notice you may be expected to pay a missed appointment fee of $50.00 before another appointment may be scheduled. Appointments cancelled due to inclement weather or emergency situations as understood by the counselor are exempt from the missed appointment fee.

Clients are encouraged to arrive promptly for their counseling session. If a client arrives late, the counseling session will end at the regularly scheduled time and the client will be charged at the full rate. The counselor reserves the right to cancel the session if the client is at least 15 minutes late.

If the counselor cancels the appointment for reasons unrelated to the client, the client will be notified as soon as the conflict has been determined. If the counselor is late for the session, the client can expect a full, 55-minute session. The client will not be penalized for any scheduling conflicts or delays by the therapist.

** Initial here if you understand and agree to adhere with this Cancellation Policy: _____ _____

CONFIDENTIALITY CLAUSE

The privacy and confidentiality of our conversations and records are a privilege of yours and are protected by our ethical principles in all but a few circumstances. Those exceptions are limited to the following: 1) known or suspected child or elderly abuse or neglect; 2) court order; 3) active suicidal ideations or intent to harm another; and, 4) counseling that is mandated by a legal authority. If counseling was mandated by a legal authority, it is assumed by your signature that you agree that your counselor may give/receive updates and opinions and share records for the purpose of professional continuity.

As a para-church ministry, we would prefer to work together with the church where you hold membership for the purpose of cooperative pastoral care. A signed, separate release form will be necessary.

** Initial here if you understand and agree with this Confidentiality Clause: _____ _____

PHILOSOPHY OF SOUL CARE

We are committed to providing professional, biblically-based counseling to all whom we serve, regardless of sex, race, religion, or sexual preference. We believe that an individual's emotions, thoughts, behaviors, and interactions are *caused* by motives that stem directly from the heart. Though the cause of most behaviors comes from the heart, we recognize that we are created as spirit and body. Therefore, we recognize that many actions and interactions are *influenced* by our body chemistry (hormones, deficiencies, adrenaline, etc.) as well as our situations and circumstances. It is our desire to provide counseling that is God-centered, Spirit-led, and Hope-focused to help clients find peace emotionally, relationally, and spiritually.

We believe that our past influences affect present realities and relationships. We will focus on the heart's responses to past and present influences and address some of the foundational issues of worth, love, and trust. In Biblical counseling, you can expect practical & Biblical directions on how to live by faith, renew the mind, manage emotions, resolve trauma of the past, and pursue peace in relationships.

When necessary we will work with your physician or psychiatrist to ensure you receive the appropriate medical care in conjunction with the counseling services you receive.

* * Initial here if you understand and agree with this Philosophy of Care: _____ _____

WAIVER OF LIABILITY

In seeking counseling from *Biblically Centered Counseling,* you must acknowledge your understanding of the following conditions and further release *Biblically Centered Counseling* from any legal liability, claim, or litigation arising from your participation in this voluntary program:

1. All counseling will be provided by Dr. Donald MacKenzie, an ordained minister, with a D. Min. in counseling.
2. All counseling is provided in accordance with the Biblical principles adhered to by *Biblically Centered Counseling* and are not necessarily provided in adherence to any local or national psychological or psychiatric association;
3. No representation has been made, either expressly or implied, that the biblical counseling, as conducted by the above mentioned counselors, is accepted as customary psychological and/or psychiatric therapy within the definitional terms utilized by those professions;

** Initial here if you understand and agree with this Waiver of Liability: _____ _____

CONSENT TO COUNSEL

Having read and understood *Biblically Centered Counseling's* Financial Policy, Appointment Cancellation Policy, Confidentiality Clause, Waiver of Liability, and Philosophy of Care,

I, _____ (print parents' name(s)) grant permission for *Biblically Centered Counseling* to render counseling services to me and the names listed below (minors):

_____ _____ _____

_____ _____ _____

I also understand that *Biblically Centered Counseling* may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, failure to pay for services rendered.
Please sign to indicate the following:

1. You have read the policies in this document;
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into counseling of your own will.

1. Parent Signature _____Date:_____

2. Parent Signature (if applicable) _____Date: _____

3. Client Signature (if applicable) _____Date: _____