

**SAMARITAN COUNSELING CENTER**  
**CHILD/TEEN REGISTRATION FORM**

This information requested in this form will be kept confidential, and will help your counselor to assist you. Please fill out the form as completely as you can.

**PERSONAL INFORMATION**

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Your racial/ethnic identity: (Optional) \_\_\_\_ African-American \_\_\_\_ Native American  
\_\_\_\_ Asian-American \_\_\_\_ White/Caucasian \_\_\_\_ Hispanic \_\_\_\_ Other \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Parent's Cell: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Guardian/parent: \_\_\_\_\_

**RELIGIOUS INFORMATION**

Are you active in any religious activities? \_\_\_\_ Yes \_\_\_\_ No

Your current place of worship (If applicable) \_\_\_\_\_

**EDUCATION INFORMATION**

\_\_\_\_ Cyber School \_\_\_\_ Home School \_\_\_\_ Regular Education \_\_\_\_ Special Education

Name of School: \_\_\_\_\_ Current Grade: \_\_\_\_\_

How many days of school have you missed this year? \_\_\_\_\_

What do you like about school? \_\_\_\_\_

What don't you like? \_\_\_\_\_

Extra curricular activities (clubs, sports, interests) \_\_\_\_\_

**FAMILY INFORMATION**

Who do you live with?  both parents  one parent  shared custody  
 guardian  other \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Age \_\_\_\_\_

Current status:  Single Parent  Married  Separated  Divorced  
 Re-Married  Other \_\_\_\_\_

Employer of Parent/Guardian (who insurance is under) \_\_\_\_\_

Do you have Siblings?  Yes  No

Only Child  Number of Brothers \_\_\_\_\_ Number of Sisters \_\_\_\_\_

Step-Brothers \_\_\_\_\_ Step-Sisters \_\_\_\_\_ Half-Sisters \_\_\_\_\_ Half-Brothers \_\_\_\_\_

**PROBLEM DEFINITION**

State in your own words the concerns you are bringing to counseling:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check the following that describe some of your problems:

Anxiety  School Anxiety  Grief  Depression  Nervousness

Attention issues  Shyness  Irrational Fears  Anger

Loneliness  Stress  Self Esteem  Chronic Fear  Guilt

Suicidal feelings  Self harm behaviors  Conflicts at home

Conflicts at school  Relationship to parents  Relationship to siblings

Relationship to friends  Relationship with God  Loss of meaning in life

Other: Describe \_\_\_\_\_

What would you like to see happen as a result of counseling? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL/PSYCHOLOGICAL HISTORY:**

Name and address of your physician: \_\_\_\_\_

When was your last medical examination? \_\_\_\_\_

List all current physical illnesses or symptoms: \_\_\_\_\_

List any allergies: \_\_\_\_\_

List major surgeries or illnesses in the last five years: \_\_\_\_\_

List current medications: \_\_\_\_\_

Current Weight \_\_\_\_\_ Weight 6 months ago \_\_\_\_\_ Height \_\_\_\_\_

Have you received counseling before: \_\_\_YES \_\_\_NO

Name of therapist: \_\_\_\_\_ School Counselor: \_\_\_\_\_

Dates: \_\_\_\_\_

How many time did you go? \_\_\_ Less than 5 times \_\_\_ More than 5 times

Did you see the counselor weekly? Yes\_\_\_ Bi-weekly\_\_\_ Monthly\_\_\_

Please indicate if these statements are true or false for you:

Do you have thoughts of suicide or harming yourself? YES NO

If so, are these thoughts of suicide or harming yourself frequent: YES NO

Do you dwell on these thoughts and wonder if you can control them: YES NO

Do you intend to act on these thoughts: YES NO

Do you have thoughts of injuring or harming others: YES NO

If so, are these thoughts of injuring or harming others frequent: YES NO

Do you dwell on these thoughts and wonder if you can control them? YES NO

Do you intend to act on these thoughts: YES NO

**SUBSTANCE USE**

Have you ever consumed alcohol? YES NO

If yes please name the type of alcohol(s) you have tried and how often: \_\_\_\_\_

When did you first consume alcohol? \_\_\_\_\_ Age \_\_\_\_\_

Have you ever consumed any non-prescription drugs: YES NO

If yes please name of drugs and how often you have used: \_\_\_\_\_

When did you first consume? \_\_\_\_\_ Age \_\_\_\_\_

Is your family aware of your use? YES NO NOT SURE

Have you received counseling for drug or alcohol use? YES NO

Where and when? \_\_\_\_\_

**INTERNET USE:**

How many times per day are you on the internet for non-school related purposes? \_\_\_\_\_

(Total amount of time per day): \_\_\_\_\_

Please check type of internet use?  Social Networking  Games  Surfing

other (please list) \_\_\_\_\_

Please list anything else you would like your therapist to know about you:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACKNOWLEDGEMENT:** Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

CLIENT SIGNATURE

DATE