FAMILY LIFE MINISTRIES – INTAKE FORM FOR MINORS

1 CECELIO AVENUE, KINGSTON 10 Phone: (876) 926-8101, 929-4360, 920-1034

117 CECILLE AVENUE, PORTMORE, ST. CATHERINE Phone: (876) 939-7917

Date:{{filedate}} Counsellor**:** {{counsellor}}

Name of Client:{{client.name}} Gender: {{gender}}

Address: {{client.livingaddress}}

Date of Birth: {{client.birthdate}} Age at last birthday: {{current\_age}}

Name of School: {{client.school}} Grade/Class/Form:{{client.grade}}

Religious Affiliation: {%if religous == “rel\_pos” %}{{religion}}{% else %}NONE{% endif %}

**Name of Parent/Legal Guardian of child {{guardian}}**

Age Group: {{age\_group}}

Address: {{guardian\_livingaddress}}

Telephone: (home) {{contact\_home}} (work) {{contact\_work}} (mobile) {{contact\_mobile}}

On which number may we leave a confidential message? {{confidential}}

E-mail Address: {{contact\_email}}

Occupation: {{guardian\_occupation}}

**Source of referral**: {{referral.true\_values()}}

Have you obtained services from FLM before?{%if first\_time\_check == False%}No{%else%}Yes : When/Year {{last\_contact}}{%endif%}

**May we contact you 3 months after termination of counselling?** {%if followup\_notice == True%}Yes{%else%}No{%endif%}

**Are you required by a Court of Law to receive counselling for your child/children as part of a legal proceeding?** {%if legal\_check == False%}No{%else%}Yes: Is a report\* required after therapy? {%if report\_check == True%}Yes{%else%}No{%endif%}{%endif%}

*\*Note: Reports may attract additional charges.*

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**Please Identify the Main Area(s) in which your Child is having Challenges:**

1. **Difficulty getting on with people in general:**

{{interpersonal\_difficulty.true\_values()}}

1. **Conflict within the family:**

{{family\_difficulty.true\_values()}}

1. **Child’s / Teenager’s Attitudes / Behaviours:**

{{behaviour\_difficulty.true\_values()}}

1. **Addiction:**

{{addiction\_difficulty.true\_values()}}

1. **Other Issues:** {{other\_difficulty.true\_values()}}

**When problem(s) began**: {{problem\_start}}

Has the child seen anyone else about this/these problem(s) ? {%if other\_consult == “consult\_false”%}No{%else%}Yes, who? {{other\_consultant}}

If yes, what suggestions did you receive on the child’s behalf? {{external\_notes}}

What did you do in response to the suggestions ?

{{external\_reaction}} {%endif%}

What would you say are your main counselling goals for your child/children ?

➀ {{goal\_first}}

➁ {{goal\_second}}

➂ {{goal\_third}}

**Illness/Condition/Allergies**: {%if illness\_notif== False%}No{%else%}Yes Specify {{illness\_list}}{%endif%}

Child’s Primary Care Physician {{physician\_name}} Phone (if known) {{physician\_contact}}

Psychiatrist {{psychiatrist\_name}} Phone (if known) {{psychiatrist\_name}}

Please list any current medication {{medication}}

Hospitalization (last 12 months){%if hospit\_notif == “hospit\_false”%}No{%else%}Yes{%endif%}

Any additional information you want your counsellor to know {{notes}}