Methodist Counseling and Consultation Services
Minor Client Intake Face Sheet

Date of Initial Visit ______________ Social Security No. _________ - _____ - __________

First Name ____________________ MI ______ Last Name _______________________ Date of Birth __________

Address____ City _________________ State _____ Zip ___________

Name of School Attending ___________________________________Grade_____________Phone_______________

Parents (please check custodial parent):

☐ Mother ____ Date of Birth __________________

Address_____________________________________ City _________________ State _____ Zip___________

Home Phone (   ) _________________________ Okay to leave message? Yes ☐ No ☐

Work Phone (   ) _________________________ Okay to leave message? Yes ☐ No ☐

☐ Father ____ Date of Birth __________________

Address_____________________________________ City _________________ State _____ Zip___________

Home Phone (   ) _________________________ Okay to leave message? Yes ☐ No ☐

Work Phone (   ) _________________________ Okay to leave message? Yes ☐ No ☐

Mother's Occupation __________________________________

Father's Occupation ___________________________________

List All Who Are Living in Household:

Name	**Relationship**	**Age**

Recent deaths of family/friends (Relation/dates) ____

____

Person Responsible for Payment ______________ Type of Counseling: ☐ Individual; ☐ Couple; ☐ Family; ☐ Group

Demographic Information

Racial/Ethnic Identity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ________

Religious Preference _______________________ Local Congregation ______________________________________

Who referred you to our Center? ____

Emergency Contact Person ____ Telephone _____________________

(Continued on the Back)

PARENTAL EMPLOYMENT DATA

Employer ____ Length of Employment _____________

Type of Work You Do ____

HEALTH DATA

List current illness(es) or symptoms ____

List any major surgeries, serious crises, losses, or handicaps (with dates) _____________________________

____

Last medical exam (date) _______________ Reason ____

Name and Address of Physician ____

____

Have you ever received counseling or other treatments for personal, marital, or family problems? ☐ Yes ☐ No

Dates _______________ Name of Professional (Dr., agency, pastor, etc.) _________________________________

Substances used ____

Current medications (and doses) ____

Please describe your reason(s) for seeking help ____

____

____

____

What would you like to have happen for you as a result of pastoral counseling? ___________________________

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FOR OFFICE USE ONLY

Center (Charlotte) ☐ Terry Bldg ☐ Blair Road UMC ☐ University City UMC ☐ Dilworth UMC

(Other) ☐ Hickory ☐ Statesville ☐ Monroe ☐ Gastonia ☐ Shelby

Therapist ___________________________________ Full time ☐ Part time ☐ Intern ☐

Agreed upon fee ___________ Diagnosis (DSM-IV) ____

Referred by: ☐ Self ☐ Clergy ☐ Physician ☐ Attorney ☐ Social Agency ☐ School Personnel ☐ Court Order

☐ Other Counselee ☐ Brochure ☐ Yellow Pages ☐ Other ___________________________________

Length of visit: ☐ Half Hour ☐ Hour ☐ Hour and Half ☐ Two Hours