Spring Of Hope
Prayer-Counseling Ministry

230 S. Potomac Street *(717) 762-0234* *Waynesboro, PA 17268*

PRE-MINISTRY HISTORY

Purpose:

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and accurately as you can, you will both save time and allow for positive, meaningful discussion. You are requested to answer these routine questions on your own time, instead of using up your actual counseling time.

It is understandable that you might be concerned about what happens to the information about you, because much or all of this information is highly personal. Case records are strictly confidential. No outsider, not even your closest relative or family member or family doctor is permitted to see your case record without your written permission.

Important:

If you do not desire to answer any question, write, "do not care to answer." Also, if some particular question does not apply to you, simply write "NA" in the space.

CHILD/ FAMILY QUESTIONAIRE

Child's name: _____ Date of birth: _____ Age:_____

Present address: _____

_____

Home phone: _____ Business phone: _____ Cell phone: _____

Race: _____ Religion: _____

Sex: M / F Birthplace: _____

School attending: _____ Grade: _____

Name(s) of adult(s) completing this form: _____

Email for adult(s) completing this form: _____

Relationship to child: _____

How long has the child had a problem for which you are seeking help?

_____

What is the main problem for which you are seeking help? _____

_____

Why did you seek help at this time? _____

_____

_____

Has the child been seen previously for psychological or psychiatric consultation?

Yes _____ No _____

If Yes: Name of professional: _____

Dates of service: _____

Place of service: _____

For what purpose: _____

Is the child adopted? Yes _____ No _____ Date: _____

Is the child a twin? Yes _____ No _____ Identical? _____

Was the child ever placed or boarded away from the family?
Yes ____ No _____ If yes; with whom? _____
Dates: _____

Has your child ever had difficulty or contact with police?
Yes _____ No _____ if yes; describe the circumstances _____
_____
_____
_____

List all those living in child's home:

Name	Relationship	Date of birth	Occupation

List other persons closely involved with the child but not living in the home (e.g., older brothers and sisters, grandparents, sitter, teacher, religious leader, etc.)

Name	Place of residence

If the child is not currently living with both natural parents

Is either natural parent deceased? _____

If so, when? _____

Were natural parents married? _____

Explain briefly any special living circumstances (foster care, custody, arrangements, visiting rights, etc.).

_____

_____

_____

Who financially supports the child? _____

How long have you resided at your present address? _____

With whom does your child share a bedroom, if anyone? _____

How would you describe the child as a person? _____

_____

_____

Has your child had problems in school? Describe briefly: _____

_____

_____

_____

Has your child repeated a grade? _____

Briefly discuss progress and behavior in school: _____

_____

_____

Does your child have many friends? _____

Does your child have difficulty making or keeping friends? _____

Difficulty with brothers and/ or sisters? _____

Family concerns (*Check X if appropriate*)

Marital difficulties _____	Death in the family _____
Aging grandparents _____	Drug addiction _____
Alcoholism _____	Financial problems _____
Serious illness _____	Single parent _____
Birth of a new child _____	Job loss _____

Other: Please specify: _____

How was the pregnancy for the mother while carrying this child? _____

_____

_____

How was the birth/delivery of this child? _____

_____

_____

Describe briefly any special interests, hobbies,
and recreational activities in which family members participate in.

Child Mother Father

_____

_____

_____

_____

Check (☑) one in each column to show when the child showed development in each area.

Early Childhood

Child walked:	Child spoke words:	Child spoke sentences:
___ 12 months	___ 12 months	___12 months
___ 12-24 months	___ 12-24 months	___12-24 months
___ 24-36 months	___ 24-36 months	___ 24-36 months
___ 36 months	___ 36 months	___ 36 months
___ had never walked	___ had never walked	___ had never walked

Child first trained for urination:	Child first trained for bowels:
___ 12 months	___ 12 months
___ 12-36 months	___ 12-36 months
___ 3-5 years	___ 3-5 years
___ 5 years	___ 5 years
___ not yet trained	___ not yet trained

Since initial toilet training:	Since initial toilet training:
___ frequent wetting during the day	___ frequent soiling during the day
___ frequent wetting during the night	___ frequent soling during the night

Onset of Puberty (breast development, menstruation, pubic hair, facial hair):

___ 10 years	___ 14-16 years
___ 10-12 years	___ 16 years
___ 12-14 years	___ not yet developed

Illnesses and diseases

Place a check (☑) next to any illness or disease which your child has had

___ asthma	___ tuberculosis	___ diphtheria	others (write names of illness)
___ eczema	___ thyroid problems	___ scarlet fever	_____
___ arthritis	___ influenza	___ polio	_____
___ diabetes	___ pneumonia	___ appendicitis	_____
___ cancer	___ migraine headaches	___ heart surgery	_____
___ anemia	___ undescended testicles	___ tonsillectomy	_____
___ measles	___ high blood pressure	___ dizziness	_____
___ mumps	___ low blood pressure	___ meningitis	_____
___ chickenpox	___ sinusitis	___ broken bone	_____
___ cerebral palsy	___ convulsions - seizures	___ liver problems	
___ lead poisoning	___ brain injury	___ allergies	
___ encephalitis	___ fainting	___ eye problems	
___ kidney problems	___ heart problems	___ memory problems - loss	
___ learning disabilities			

Hospitalizations

List any hospitalizations your child has had. Give age at which hospitalization took place and length of the hospitalizations.

Condition for which hospitalized	Child's age	Length of hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. What is the child's favorite plaything? _____
_____

2. How long does the child play with one toy? _____

3. Is your child responsible for keeping its toys in order? _____

4. Does the child play with the toy or take it apart? _____

5. Does your child collect anything? _____

6. Does your child have a favorite game? _____

7. How does your child play the game; can she/ lose without getting upset? _____
_____

8. If your child is given a choice, what would she/ he choose to do? _____
_____

9. How much time does your child watch TV? _____

10. What is his/ her favorite program? _____

11. Does your child play Nintendo/ Sega? Play Station/Game Boy? How much time does she/he spend doing it?
_____
_____

12. Does your child like to draw or color? _____

13. Does your child join in with other when at a playground? _____

14. Would your child prefer to play alone or with others? _____

15. What sports, if any, does your child enjoy? _____
_____

When you called Spring of Hope Ministries, did you already know who you wanted to be your counselor?
Yes __ No __ If yes, who? _____
Who referred you to Spring of Hope Ministries? _____

Do we have your permission to call your listed home telephone number the day prior to your appointment to remind you of your appointment? Yes ___ No ___

Please answer the following questions with reference to the child listed below:

Child's Name: _____ Age: _____

Items to access:	YES	NO	Sometimes – Please Explain
1. Restless or Hyperactive?			
2. Acts without thinking?			
3. Difficulty Concentrating?			
4. Clumsy or poorly Coordinated?			
5. Gets hurt a lot - Accident prone?			
6. Nervous or high strung?			
7. Worries a lot?			
8. Excessively fearful?			
9. Clings to adults - Overly dependent?			
10. Avoids going to school?			
11. Has nervous habits?			
12. Has nervous movements or twitching?			
13. Keeps thinking about the same thing?			
14. Repeats certain acts over and over?			
15. Overly concerned with neatness?			
16 .Feels a need to be perfect?			
17. Feels overly guilty?			
18. Shy or Timid?			
19. Not liked by others?			
20. Would rather be alone than with others?			
21.Gets teased a lot?			
22. Plays mostly with children much older or younger?			
23. Acts very mature?			
24. Behaves like the opposite sex?			
25. Self conscious - easily embarrassed?			
26. Unhappy, sad or depressed?			
27. Has eating habits - picky or abnormal?			
28. Has trouble sleeping or sleeps too much?			
29. Has nightmares?			
30. Talks about killing self?			

Child's Name:			**Page 2 of 3**
Items to access:	**YES**	**NO**	**Sometimes – Please Explain**
31. Deliberately harms self or attempted suicide?			
32. Very low energy?			
33. Cries a lot?			
34. Feels worthless or inferior?			
35. Argues a lot?			
36. Shows cruelty, bullying or meanness toward others			
37. Destroys property?			
38. Cruel to animals?			
39. Doesn't feel remorse or guilty after misbehaving?			
40. Gets into physical fights?			
41. Hangs around with others who get into trouble?			
42. Sets fires?			
43. Steals?			
44. Lies often?			
45. Disobedient at home?			
46. Disobedient at school?			
47. Disrespectful to adults?			
48. Truant from school?			
49. Swears excessively?			
50. Frequent temper tantrums?			
51. Does poorly in schoolwork?			
52. Has a speech problem?			
53. Shows off or clowns around excessively?			
54. Wets the bed or wets during the day?			
55. Soils?			
56. Smears bowel movement?			
57. Inappropriate sexual behavior?			
58. Confused or in a fog?			
59. Refuses to talk?			
60. Secretive - keeps things to oneself?			
61. Stores thing up they don't need?			
62. Excessively irritable?			
63. Stubborn?			

Child's Name:			**Page 3 of 3**
Items to access:	**YES**	**NO**	**Sometimes – Please Explain**
64. Runs away from home?			
65. Believes people are out to get them			
66. Hears sounds or voices that aren't there?			
67. Sees things that aren't there?			
68. Strange ideas?			
69. Uses alcohol or drugs?			

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PARENTAL RELEASE AND DISCLAIMER FORM

You have a right to know: Disclosure, Information and Agreement

The purpose of this ministry is for spiritual growth and healing. It is not a psychological counseling service nor is it intended to be. I/We understand that the team members are not licensed psychologists or psychiatrists, but are trained in using the Word of God and prayer through the power of the Holy Spirit. The results of this approach depend on the willingness of my/our child(ren) to make wise choices consistent with the teaching of Jesus Christ.

I/We further understand that according to I Corinthians 6:1-8 we as Christians should refrain from suing one another, and that all healing prayer ministry is being undertaken with the understanding that we will abide by that scriptural premise.

All personal information gathered in the course of ministering to my/our child(ren) is confidential, and the files are so maintained. I/We understand that information will be shared with me/us, the child(ren)'s parent(s)/legal guardian(s), when/if the counselor deems appropriate. I/We do hereby give permission for the counselor to consult with other members of the counseling team as is needed (names are withheld).

Intern Counselor Training is a part of our commitment to the task of restoration and transformation to individuals and families. As your child(ren) participate(s) in the counseling session they may have the opportunity to work with their counselor and a qualified intern who has been assigned. Please be assured that we always adhere to a strict policy of confidentiality, which includes the interns working with counselees.

In order to comply with legal regulations, any planned or recently attempted suicide, threats, child abuse, severe psychosis or severe emotional dysfunction, or criminal behavior will be reported to the proper authorities.

I/We, _____ the parent(s)/legal guardian(s) of _____ understand the foregoing information concerning this ministry. I/We have sought this ministry of our, along with our child(ren)'s own free will and all personal information, both individual and family, is given voluntarily in order to facilitate the team members working with my/our child(ren).

This ministry is supported through giving. While we do not charge a fee, we do encourage counselees to make a regular contribution of $60-$75 to this ministry each visit. Donations for services rendered are not tax deductible. Please make checks payable to Spring of Hope Ministries.

If you are unable to keep this appointment time, please contact the Spring of Hope office at 717-762-0234 24 hours prior to appointment time to re-schedule another appointment. Thank you.

_____ _____
Parent(s)'/Legal Guardian(s)'s Signature Date

_____
Printed Name