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.

PARENT QUESTIONAIRE

Teen's Name: _____ Date of birth: _____ Age: _____

Present address: _____

_____

Home phone: _____Business 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 teen: _____

How long has the teen 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? _____

_____

_____

What is your goal for having your teen come? _____

_____

Have you talked to your teen about why they are coming, and your goals and expectations? _____

Has the teen 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 teen adopted? Yes _____ No _____ Date: _____

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

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

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

List all those living in the teen's home:

Name	Relationship	Date of birth	Occupation

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

Name	Place of residence

If the teen 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 teen? _____

How long have you resided at your present address? _____

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

How would you describe the teen as a person? _____

_____

_____

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

_____

_____

_____

Has your teen repeated a grade? _____

Briefly discuss progress and behavior in school: _____

_____

_____

Does your teen have many friends? _____

Does your teen 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 teen? _____

_____

_____

How was the birth/delivery of this teen? _____

_____

_____

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

Teen Mother Father

_____

_____

_____

_____

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

Early Childhood

Teen walked:	Teen spoke words:	Teen 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

Teen first trained for urination:	Teen 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 soiling during the night

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 teen has had

___ asthma	___ tuberculosis	___ diphtheria	others (write names of illness
___ eczema	___ head disease	___ 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		
___ lead poisoning	___ brain injury		
___ encephalitis	___ fainting		

Hospitalizations

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

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

1. What is the teen's favorite activity? _____
_____

2. Is your teen responsible for keeping its room in order? _____

3. Does your teen collect anything? _____

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

_____

5. How much time does your teen watch TV? _____

6. What is his/ her favorite program? _____

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

_____

_____

8. How does your teen interact with others? _____

9. Would your teen prefer to be alone or with others? _____

15. What sports, if any, does your teen 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 ___

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MINISTRY RELEASE AND DISCLAIMER FORM

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

The purpose of this counseling ministry is for healing of the heart and personal growth. Our team members 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 the individual to make wise choices consistent with the teaching of Jesus Christ. Spring of Hope is not a psychological counseling service, nor is it intended to be. I understand that the team members are not licensed psychologists or psychiatrists. While all of our prayer counselors are trained by the Elijah House schools, most of our Prayer Counselors have gone on to continue their education in counseling.

I further understand that according to I Corinthians 6:1-8 we should refrain from suing each other and that all healing prayer ministry is being undertaken with the understanding that we will abide by that scriptural premise. Accordingly, I understand that it would be counterproductive to the wellbeing of the parties participating in counseling and prayer ministry for information and discussion generated during the counseling sessions to be released to any court or attorney for the purpose of litigation. The release of such information sabotages the therapeutic relationship and does not foster an environment which would be beneficial to the therapeutic process. I hereby agree that I will not request such information for any litigation purpose, and I will not cause any court to issue any subpoena or other order for any counselor in this ministry to testify on my behalf in any case. Furthermore, I agree that the records generated by this counseling ministry based on my participation in the ministry are confidential, and that the counseling ministry can properly refuse to testify and/or to release such information to any attorney, custody evaluator appointed by the court, or any other officer of the court without court order.

All personal information gathered in the course of a prayer counseling session is confidential, and the files are so maintained. I do hereby give permission for the prayer counselor to consult with other members of the counseling team as is needed (names are not used).

Supervision of Children: It is our policy that children are not permitted in the waiting room without supervision, nor are they permitted to be in the counseling session unless they are a part of the scheduled appointment.

Intern Counselor Training is a part of our commitment to the task of restoration and transformation to individuals and families. As you are participating in the counseling sessions, you may have the opportunity to be working with your prayer 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.

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

I, _____ understand the foregoing information concerning this ministry. I have sought this ministry of my own free will and all personal information I reveal is given voluntarily in order to facilitate the team members working with me.

This counseling ministry is supported through giving. Although we are non-profit, we recommend that each client contribute a donation for services rendered. Our suggested minimum donation is $60-$75 per session; however donations given beyond this will be greatly appreciated. Counselees may seek financial assistance from their church, employer or other sources.

Make checks payable to Spring of Hope Ministries.

If you are unable to keep this appointment time, please contact the Spring of Hope office 24 hours prior to appointment time to re-schedule another appointment!

_____ _____

Signature Date

Printed Name _____