Counseling Intake Form

# CONFIDENTIAL

“*Life History” Questionnaire*

**Contact Information** Today’s Date: \_

Name: \_ Male / Female Address: City: State: Zip: Date of Birth: \_ Referred by:

Phone: home/work or cell: \_\_\_ May I call: Yes/No Leave MSG: Yes/No

E-mail:

May I Email: Yes/No

In case of emergency, who can we contact?

Name Relationship Phone Number

## Presenting Problem

***Please state in your own words the main reason for seeking counseling.***

**Please Circle Any Of The Following Which Concern You:**

|  |  |  |  |
| --- | --- | --- | --- |
| Nervousness  Sexual Problems | Depression  Suicidal Thought | Fears  Separation | Shyness  Divorce |
| Finances | Anger | Self-Control | Friends |
| Sleep Problems | Stress | Work/School | Relaxation |
| Headaches | Tiredness | Legal Matters | Memory |
| Ambition  Loneliness | Energy  Inferiority Feelings | Insomnia  Concentration | Making Decisions  Education |
| Career Choices | Marriage/Relationships | Health Problems | Temper |
| Nightmares | Children | Eating Problems | Unhappiness |
| Sexual Abuse  My Thoughts | Physical Abuse  Stomach Problems | Bowel Troubles  Gambling | Being A Parent  Binge Eating |
| Eating Too Little | Too Heavy Or Thin | Spirituality | Unforgiveness |

**Please Circle Any Of The Following Strengths You Have:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Confident | Hard Worker | Organized | Sympathetic | Good Listener |
| Dependable | Sensitive | Logical | Loyal | Gracious |
| Decisive Responsible | Understanding | Sense Of Humor | Patient |  |

**Please circle the severity of your problems:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mildly | Moderately | Very | Extremely | Totally |
| Upsetting | Upsetting | Upsetting | Upsetting | Upsetting |

When did your problems begin? *Please give dates.*

Please describe significant events occurring at the time, or since then, which may relate to the development or maintenance of your problems.

Have you been in counseling before or received any professional assistance for these or other problems? Yes No

*If so, please give names, professional titles,dates of treatment and results.*

Have you ever been hospitalized for psychological problems? Yes\_\_\_No \_ If yes, when and where?

## Please complete the following sentences:

I came here today…, My marriage…,

Growing up in my family…,

If I could change one thing…, Six months from now…,

## PERSONAL AND SOCIAL HISTORY

Are you a student? Yes\_\_\_ No Where? Studying what? \_

Employed? Yes\_

No

Full Time Part time

Employer \_ \_ Occupation \_ \_ **Marital Status (circle one)**

Single Engaged Married Separated Divorced Widowed Name of your Spouse (current)\_\_ \_ \_

Spouse’s Age

Spouse’s Occupation\_

\_ When married?\_

How long did you know one another before your engagement? \_

PREVIOUS MARRIAGES: (List how long you were married and the reason for the end of the marriage)!

**CHILDREN: Please list children by sex, name, and age.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Male/Female** | **Age** | **Your Relationship** | **Issues** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**SIBLINGS: Please list all of your siblings by sex, name, age.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Male/Female** | **Age** | **Your Relationship** | **Issues** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**FATHER**

If your father is living, what is his age? \_ State of his health? \_ State of your relationship? If your father is deceased, what was his age at the time of death? \_ How old were you at the time? \_ Cause of death? \_

**MOTHER**

If your mother is living, what is her age? State of her health? \_ State of your relationship? If your mother is deceased, what was his age at the time of death? \_ \_ How old were you at the time?\_ Cause of death? \_ \_ **Please let me know about your relationship with step parents!**

**FRIENDS**

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? Yes\_ No

## Circle any of the following that applied during your childhood/adolescence:

Happy Childhood School Problems Medical Problems Unhappy childhood Family Problems Alcohol Abuse Emotional / Behavior Problems Incest Strong Religious Convictions Drug Abuse Legal Problems Other

## RELIGION

As a child? \_ As an adult? \_ Church Affiliation: \_ Pastor \_ Do you find religion: satisfying challenging \_ dull meaningless\_ irrelevant How often do you attend church?

How often do you read the bible?

How often do you pray?

## EDUCATION

Last grade completed? \_ \_ Degree? \_

*How would you describe your academic performance:*

Excellent \_ Above Average\_

Average

Low Average \_\_ Poor\_

What were scholastic strengths and weakness?

Did you date much in high school? Yes\_ Did you date much in college? Yes\_

No \_ No \_

## MEDICAL HISTORY

Do you have a family physician*? If YES, please provide the following*:

Physician’s Name \_

Address \_ \_ Phone Number \_

Have you ever attempted suicide? Yes\_\_ No

Does any member of your family suffer from, Alcoholism, Epilepsy, Depression, Mental Disorders?

*If yes, please describe:*

Has any relative attempted or committed suicide? Yes\_\_ No

*If yes, please describe:*

Has any relative had serious problems with the law? Yes\_\_ No

Do you own a gun? Yes\_

No \_

Do you have any current concerns about your physical health? Yes\_\_ No If YES describe:

Are you currently taking medications? Yes\_

No

If yes, please list any medications you are currently taking, or have taken during the past six months

## include aspirin, birth control, and prescription or over the counter medicines.

**Please list any possible hereditary health conditions in your family!**

Are you currently (or have ever been) in an abusive relationship? Yes\_\_ No\_

## CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **NEVER** | **RARELY** | **FREQUENTLY** | **VERY OFTEN** |  |
|  | **Marijuana** |  |  |  |  |
|  | **Tranquilizers** |  |  |  |  |
|  | **Sedatives** |  |  |  |  |
|  | **Aspirin** |  |  |  |  |
|  | **Cocaine** |  |  |  |  |
|  | **Painkillers** |  |  |  |  |
|  | **Alcohol** |  |  |  |  |
|  | **Coffee** |  |  |  |  |
|  | **Cigarettes** |  |  |  |  |
|  | **Narcotics** |  |  |  |  |
|  | **Stimulants** |  |  |  |  |
|  | **Hallucinogens, LSD** |  |  |  |  |
|  | **Diarrhea** |  |  |  |  |
|  | **Constipation** |  |  |  |  |
|  | **Allergies** |  |  |  |  |
|  | **High Blood Pressure** |  |  |  |  |
|  | **Heart Problems** |  |  |  |  |
|  | **Nausea** |  |  |  |  |
|  | **Vomiting** |  |  |  |  |
|  | **Insomnia** |  |  |  |  |
|  | **Headaches** |  |  |  |  |
|  | **Backaches** |  |  |  |  |
|  | **Early Morning Awakening** |  |  |  |  |
|  | **Fitful Sleep** |  |  |  |  |
|  | **Overeat** |  |  |  |  |
|  | **Poor Appetite** |  |  |  |  |
|  | **Eat “Junk Foods”** |  |  |  |  |
|  | | | | | | |

Is there anything else you feel I should know about you and your situation?

# DISCLOSURE AND CONSENT FORM

## GENERAL

Since counseling is based upon a particular theoretical orientation as well as the personal style and

experience of the counselor, I believe it is in your best interest to briefly explain to my views of the counseling process. In addition, I wish to clarify my administrative policies to avoid any future misunderstandings.

## VIEW OF THE COUNSELING PROCESS

I believe in the sufficiency of God’s Word to handle issues of life. We follow the Bible’s description of man as a fallen creature living in a fallen world. The solution for living in this world is found in God’s Word. I am trained to lead you to Scriptures that deal directly with the issues you are facing. I want to show you where the Bible says you are, where the Bible says you should be, and most importantly how to get there.

We are confident that the Bible has all the information necessary for life and godliness. The Bible says in

**2 Peter 1:3-4** that God's *"divine power has granted to us everything pertaining to life and godliness, through the true knowledge of Him who called us by His own glory and excellence. For by these He has granted to us His precious and magnificent promises, in order that by them you might become partakers of the divine nature, having escaped the corruption that is in the world by lust."*

There are no problems between persons or in persons that the Bible fails to address either generally or specifically. Biblical counseling involves giving Scriptural teaching and making practical [application](http://www.fbcfm.org/firstbaptistflowermound/biblical_counseling) to counselees. The Bible will be the authority in all cases.

I view the counseling process as forming an alliance with you, in dependence on God, to explore the nature of your problem. Although we will spend much of our time exploring the specific problem that brought you into counseling, we will also explore, in depth, the nature of your relationship with God and other significant people in your life.

## DESIRES AND RESPONSIBILITIES OF COUNSELOR

I desire to see the problem that brought you into counseling resolved to your satisfaction. I also desire to see you entering deep joy and growing in your ability to love others powerfully. In order to help you, I need to get to know you, how you view your problem and how you relate to significant people in your life. I am responsible to be honest with you, and to keep careful records about the directions we pursue in counseling (these records are confidential; no one else will be allowed to see them). I will follow a course of counseling that is in your best interest, and will attempt to resolve only those problems that are within the scope of my training.

## CONFIDENTIALITY

Confidentiality is an important element of the therapy process. Your identity and ongoing work in therapy will be kept strictly confidential, with only the following exceptions:

* I regularly consult with other professionals regarding clients with whom I am working. This allows me to gain other perspectives and ideas on how to best help you reach your goals. Such consultations are obtained in a way that maintains complete confidentiality. No identifying information is shared in such consultations.
* If a court of law orders a subpoena of case records or testimony I will first assert “privilege” (which is your right to deny the release of your records). I will release records with your written permission or if a court denies the assertion of privilege and orders the release of records.
* If I feel you are a threat to yourself or others (suicidal or homicidal statements) I may need to report these statements to your family and/or other appropriate mental health or law enforcement professionals.
* There are a broad range of events that are reportable under child protection statutes. Physical or sexual abuse of a child will be reported to Child Protective Services. When the victim of child abuse is over the age of 18, I am not legally mandated to report it unless I believe that there are minors still living with the abuser who may be in danger of being abused.

## FEES AND PAYMENT OF FEES

The standard fee for individual counseling is $75.00 per fifty minute session. The group and couples rate is $105.00 per ninety minute session. The first session has a $40.00 per person initial fee. Fees are paid at the end of each counseling session by personal check, cash or credit card. Arrangements other than this must be made with me. Financial considerations are a real and necessary part of counseling. Openness and flexibility are necessary when determining a client’s financial obligation and I sincerely invite you to discuss your fee with me at any time during this relationship.

Appointments are generally made on a regular, weekly, bi-weekly or monthly basis. In the event you are unable to keep your appointment, a 24 hour notice is required for cancellations. Except for emergencies, you will be charged full fee for a “no show” or for a cancellation without a 24 hour notice. If you are attending a group, you will be required to pay for your place in group whether present or not.

When a client is a minor, counseling fees are the responsibility of the parent/parents or legal guardian. If there is a need for psychological testing, fees are additional and are determined according to the number and type of test(s) administered.

## CLIENT’S RIGHTS AND RESPONSIBILITIES

The course of therapy is determined mutually by myself, the counselor, and you, the client. You are encouraged to freely ask me any questions you have regarding my educational and professional background, therapeutic approach, and the specific therapy plan and progress.

People often ask how long they will be in counseling. Some clients need fairly brief therapy to understand their conflicts and reach the goals they set for themselves. However, others may require many months or even years of work to achieve the growth they desire. I attempt to work with people in such a way that they have sufficient time to meet their individual therapy goals but I discourage clients becoming inappropriately dependent upon therapy. Consequently, treatment duration varies from person to person. Clients typically know when they are beginning to “feel finished” with therapy work and I encourage you to discuss this when it happens for you so that we can close our relationship as carefully as we begin it.

It is your responsibility to determine whether the services offered are appropriate and ultimately helpful. It is always my intention to provide services in a professional manner that is consistent with all accepted ethical standards. If at any time in the course of our work together you feel that there may have been a misunderstanding or you have any question or complaint about my services, please bring this up with me immediately so that I can become aware of your concern and resolve the matter with you. You have the right to end therapy at any time without any moral or legal obligations. Financial obligations will be only those already accrued. If you choose to end the counseling relationship, I do ask that you participate in a termination session.

For the safety and welfare of your child, parents of minor children must remain on the premises and available to the counselor while their child is in session. Please note that if you are waiting on the premises but away from our lobby you need to come in at least 10 minutes prior to the end of your child’s session so that you are available to your child and their counselor when the session is over.

## COMMUNICATIONS

Email/ texting is not a secure or confidential medium, I cannot guarantee that any email/text that you may send to me will remain confidential. I do consider your communications private and do all I can to maintain confidentiality. If you choose to email/text me, include a phone number where I may reach you if a reply is requested. I do monitor email/text messages throughout the day, but **EMAIL/TEXTING IS NOT RECOMMENDED AS A METHOD FOR CONTACTING ME IN AN EMERGENCY.**

Please note that if you choose to email/text me and I decide to respond, I will respond to the address/phone number from which it is sent. If you do not wish others who may have access to the email/text account you are using to also have access to my response, please consider another means of contacting me.

## ACKNOWLEDGEMENT

By signing this disclosure and consent statement, the client acknowledges having been informed of his/her rights and responsibilities. In addition, the client acknowledges he/she has read and understands the administrative policies for this counseling office.

Signature of client Date

Signature of Spouse/Guardian Date