Intake Form (Confidential)

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can.

Name:_____Date of Birth:_____Age:_____Sex:_____

Present Address: _____
Number Street

_____
City County State Zip Code

Phone/Cell:_____Email: _____

Do we have permission to call or text you at this phone number? _____ Yes _____ No

Presently living with: Parents_____Spouse_____Roommate_____Alone-Other_____

Marital Status: Single_____ Married_____ (# of Years_____) Divorced_____ Separated_____

Family member to notify in case of emergency: Name: _____

Address:_____ Phone:_____

Referred by:_____

Church Affiliation: _____

FAMILY MEMBERS Relationship	Name	Age	Grade in School last Completed	Occupation
Spouse				
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

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Describe any physical problems you have that require medication or physical care:_____

_____

Are you currently receiving medical treatment? Yes _____ No_____

List any medications you are taking currently:

Name	Dosage	Results

List previous treatment with mental health professionals:

Date	Name of Therapist and/or Institution	Nature of Problem	Result of Treatment

In your own words, briefly describe the main problem that prompted you to seek counseling at this time:

_____

_____

Have there been times when the problem got better or disappeared? Yes_____No_____

If so, when? _____

What do you think helped?_____

_____

Were there times when the problem was especially bad? Yes_____No_____

If so, when? _____

What made it bad? _____

_____

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Are there other people who play a major role in:
1. Causing your problems? (Yes_____No_____)
2. Helping you to cope with your problems? (Yes_____No_____)

Explain briefly:_____

Describe any of the following (or other) significant life events that have happened in the last 10 years:

Check If Yes	Event	When	Description
	Death in family		
	Death of friend		
	Children leaving home		
	Employment change		
	Military Service		
	Other		

Do you have any history of abuse (physical, sexual, emotional or spiritual)?_____

_____

List your five main fears:

1. _____
2. _____
3. _____
4. _____
5. _____

Vocational History:

Have you ever had a job? _____ If yes, when and what sort of work are/were you doing?

_____

What jobs have you held in the past? _____

Does your present work satisfy you? _____ If not, in what ways are you dissatisfied?

_____

Does/did your income meet your financial needs? _____

Problem Areas: In the following list, place a check mark next to each item that identifies an area of concern to you. Place two checks by those items that are most important. (You may add comments after areas checked).

_____Anger

_____Cannot Concentrate

_____Depression

_____Education

_____Eating Difficulties

_____Feelings of Inferiority

_____Fearfulness

_____Financial Problems

_____Loneliness

_____Marital Problems

_____Memory Problems

_____Physical Problems

_____Problems with Social Relationships

_____Problems with Children

_____Problems with Parents

_____Religious/Spiritual Concern

_____Sexual Concerns

_____Sleep Problems

_____Thoughts of Suicide

_____Trouble Making Decisions

_____Unable to Relax

_____Unhappy Most of the Time

_____Use of Alcohol

_____Use of Alcohol by Family Member

_____Use of Drugs

_____Work

_____Worry

_____Other (Specify)_____

Expectations for Therapy:

What about your present behavior do you want to change? _____

_____

What feelings do you want to alter (i.e., increase or decrease)? _____

_____

What benefits do you expect to gain from therapy? _____

_____

What characteristics should the ideal therapist possess? _____

_____

What do you think therapy will do for you? _____

_____

How long do you think your therapy should last? _____

Consent to Release Information:

I hereby authorize my counselor, _____, to obtain or to share medical information such as diagnosis, treatment plan and progress with the person or persons listed below. It is understood that this authorization can be revoked at any time upon written notice.

1._____

2._____

3._____

4._____

5._____

Request for Services:

I have read the Centered for Life Information Sheet and voluntarily request counseling services in accord with terms described on the information sheet.

Signature _____

Date _____

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

Signature _____

Date _____

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION

Information Sheet

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below.

Centered for Life provides counseling from a Christian perspective for individuals, couples, families and groups. Our services are available to residents of the community regardless of race or religious affiliation. Your counselor is licensed as a mental health professional in the state of Georgia. If your situation requires a special level of care, you will be provided with a referral to other agencies.

CONFIDENTIALITY: Communications between client and counselor are confidential and will not be revealed unless required by law, such as in situations of child abuse or threats of physical harm to self or others or subpoena of a court. Communications with your counselor are generally protected by privilege but are subject to subpoena by the courts should litigation be brought against you.

COUNSELING FEES: The fee for a 50-minute session varies depending on the counselor providing services. Any other arrangement must be negotiated with your counselor. We ask that your account be kept current and that payment be made by check or cash prior to each session. A non-refundable retainer equivalent to the fee for one session is paid in advance in order to hold your appointment times and to serve as your last payment. It is our policy and the appropriate standard of care that all clients have a termination or final session in order to review progress against goals and to establish post-treatment plans.

CANCELLATION OF APPOINTMENTS: If you must cancel your appointment, please leave a message on your counselor's voicemail at least 24 hours in advance of your scheduled appointment. Your cooperation in this regard will be greatly appreciated. Failure to cancel a scheduled appointment will result in a charge of the fee for one session.

TELEPHONE CALLS: You may leave a message for your counselor 7 days a week, 24 hours a day. When calling, please leave your name and telephone number on your counselor's voicemail and your call will be returned as soon as possible.

EMERGENCY PROCEDURES: The counselors are not available to handle emergencies. If you have an emergency, you will need to contact either a hospital emergency room or the police as appropriate to the situation.

I have read the above information and voluntarily request counseling services from Centered For Life, and I agree with these terms and conditions. *

Signature:_____ Date:_____

*The signature of the custodial parent or guardian is required for clients under 18 years of age.

CENTERED for LIFE

PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is _____

2. I worry about _____

3. What I do best is _____

4. I have sometimes felt guilty about _____

5. What makes me angry is _____

6. My biggest mistakes were _____

7. My job _____

8. What makes me nervous is _____

9. My personality would be better if _____

10. I often felt that mother _____

11. Jesus Christ is _____

12. My temper _____

13. My childhood _____

14. Prayer is _____

15. My biggest disappointment _____

16. To me, sex is _____

17. I would be better liked if _____

18. I often felt that father _____

19. God to me is _____

20. My children (child) (brothers and sisters) _____

21. Women are _____

22. What hurts me most is _____

23. My biggest problem in life is _____

24. Men are _____

25. The kind of legacy I want to leave is _____

26. My Quiet Time is _____

27. I fear _____

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Form 431

Consent to use and disclose your health information

This form is an agreement between you,_____ and me. When I use the word "you" below, it will mean you, your child, or relative. It will mean any other person who you name here_____.

When I examine, diagnose, treat, or refer you I will be collecting what the law calls protected health information (phi) about you. I need to use this information to decide about what treatment is best for you and to provide the said treatment to you. I may also share this information with others who provide treatment to you or for other business or government functions.

By signing this form you are agreeing to let me use information and send it to others. The notice of privacy practice (form 411) explains your rights in more detail and also how I can use and share your information. Please read it before you sign this consent.

If you do not sign this consent form agreeing to what is in my notice of privacy practices (form 411) I cannot treat you.

In the future I may change how I use and share your information and so may change my notice of privacy policies (form 411). If I do change it, you can obtain a copy by calling me at the number above or from my lobby where copies will always be available.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his/her Personal representative

Date

_____ _____

Print name of client or personal Representative

Relationship to client

_____

Description of personal representative's authority

Date of NPP form 411_____. Copy to ___ Client ___ Parent ___ Rep.

Centered for Life Professional Disclosure Statement

Centered for Life is a Christian organization offering counseling, life-coaching and spiritual direction. In choosing the counseling services offered by this organization, you accept that Christian methods and techniques could be utilized during the counseling process, including but not limited to prayer, Bible reading and study, Christian bibliotherapy, and discussion of your personal beliefs and relationship with God.

Christian counseling is a partnership venture between God, the counselor and you. The number of visits will be determined through ongoing discussion and evaluation, based on the goals you desire to achieve. It is our goal that through working together, with God's leadership, you will find healing and hope and strength, and a deeper, more intimate relationship with Jesus Christ.

There is always the possibility that counseling will not benefit you, or that you may wish to terminate therapy. You may do so at any time in this process. You are encouraged to ask questions and be integrally involved in the direction of your treatment. A counselor is a guide, and cannot force you or coerce you against your will. You may refuse any form of treatment, intervention or technique with which you are uncomfortable for any reason. We will discuss our interventions with you in detail as we begin the counseling process.

Our service is confidential. No information disclosed during a session will be made available to anyone else, except under the following legally or ethically mandated conditions:

1. We are involved in professional dialogue, in order to insure the highest quality of care for our clients. Some information about your case may be discussed to receive suggestions or feedback, but no identifying information will be given. The information shared will be limited to that which may benefit your continued care.

2. In the case you reveal that you intend to harm yourself or others, we are required by law to take steps to protect you or the third party involved.

3. If you are using insurance to pay for sessions, they will require information about your treatment as well as a diagnosis.

4. If we are subpoenaed by a court of law we may be required to disclose information about your case.

5. If you present written authorization for us to release information to a third party, such disclosure will be made.

6. In the case of child abuse, disabled abuse, or elder abuse, we are required by law to report this information.

7. If you are involved in any activity that may harm another individual, we have a duty to warn that individual of the potential danger. You need to be aware that not all insurance policies will pay for Christian counseling services. You will be responsible for communication with your

insurance company, including determining with your insurance company if our services are covered under your policy and the submission of forms for reimbursement. We do request that you notify us at least 24 hours in advance if you cannot keep your appointment, so that we may make that time available for other clients. Otherwise, you will be charged your normal fee.

We do not offer on-call or emergency contact services. You may contact each therapist individually as needed. Please note that email and phone messages may not be confidential. After hours, if you have an emergency, please call 911.

_____ _____

Signature Date