River of Life Christian Counseling

Intake Form - Adult

TODAY'S DATE_____

CLIENT INFORMATION:

CLIENT NAME _____
Last First Middle

ADDRESS _____
Street City State Zip

HOME PHONE _____CELL PHONE _____

DATE OF BIRTH_____ _____ MALE _____FEMALE

HOW WERE YOU REFERRED TO OUR OFFICE? _____

_____

_____

_____

PLEASE LIST YOUR HIGHEST LEVEL OF EDUCATION:_____

EMPLOYER: _____
Name Title

EMPLOYER ADDRESS: _____
Street City State Zip

PHONE: _____ OK TO CALL WORK? _____YES___NO
OK TO LEAVE MESSAGE? _____YES___NO

SOCIAL SECURITY # _____

MARITAL STATUS? _____SINGLE _____ENGAGED _____MARRIED (how many times?___)
_____SEPARATED _____DIVORCED _____WIDOWED

SPOUSE NAME: _____

SPOUSE'S DATE OF BIRTH:_____

PERSON TO CONTACT IN AN EMERGENCY (name, relationship, address, phone number):

_____

_____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL? _____ DATE OF BIRTH: _____

ADDRESS (if different): _____

PHONE NUMBER: _____

OCCUPATION: _____ EMPLOYER: _____

INSURANCE COMPANY: _____

INSURANCE CLAIMS ADDRESS: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S S.S. no., _____

BIRTHDATE: _____ GROUP no.: _____ POLICY no. _____

CLIENT'S RELATIONSHIP TO SUBSCIBER: (please check one) :

_____SELF _____SPOUSE _____CHILD _____ OTHER

ADDITIONAL CLIENT INFORMATION:

PLEASE LIST THE NAMES, BIRTH DATES, GENDER AND RELATIONSHIP OF INDIVIDUALS IN YOUR IMMEDIATE FAMILY, (Please indicate whether they live at home):

NAME	BIRTH DATE	GENDER	RELATIONSHIP	AT HOME?

DO YOU ATTEND CHURCH REGULARLY? YES_____ NO _____ IF YES, WHERE?

_____

_____

BRIEFLY DESCRIBE YOUR FAITH EXPERIENCE?_____

_____

_____

_____

NATURE OF PROBLEM FOR WHICH YOU ARE SEEKING COUNSELING (briefly describe):

_____

_____

_____

_____

_____

_____

ANY PRIOR COUNSELING? YES_____ NO _____ IF YES, WHEN, WHERE, WITH WHOM AND FOR WHAT PURPOSE? _____

_____

_____

ANY CURRENT SUICIDAL THOUGHTS, FEELINGS OR ACTIONS? YES_____NO _____

IF YES, PLEASE EXPLAIN _____

_____

_____

ANY CURRENT HOMICIDAL OR ASSAULTIVE THOUGHTS OR FEELINGS, OR ANGER-CONTROL PROBLEMS? YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

ANY PAST HOSPITALIZATIONS,? YES_____ NO _____

IF YES, PLEASE EXPLAIN (dates, place, reason)_____

_____

_____

_____

_____

ANY CURRENT LIFE STRESSORS (illness, divorce, custody, job loss, etc.)? YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

ANY FAMILY HISTORY OF MENTAL HEALTH ISSUES? YES_____ NO _____

IF YES, PLEASE EXPLAIN_____

_____

_____

WHO IS YOUR PHYSICIAN?

_____

Name Address Phone

WHEN WAS YOUR LAST MEDICAL EXAM?_____

DO YOU HAVE ANY MEDICAL CONDITIONS?_____

_____

_____

_____

ANY PROBLEMS WITH: (please check all that apply

_____EATING ____SLEEPING _____PAIN _____RECENT WEIGHT CHANGES

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? (If yes please list)_____

_____

_____

_____

COMMON PROBLEM/SYMPTOM CHECKLIST: (please rate 0=none, 1=mild, 2=moderate, 3=severe)

_____God/faith	_____marriage	_____divorce/separation	_____alcohol/drugs
_____premarital	_____child custody	_____other addictions	_____church/ministry
_____singleness	_____disabled	_____grief/loss	_____past hurts
_____sexual issues	_____work/career	_____depression	_____codependency
_____family	_____school/learning	_____fear/anxiety	_____intimacy
_____children	_____money/budgeting	_____anger control	_____communication
_____parents	_____aging/dependency	_____loneliness	_____self-esteem
_____in-laws	_____weight control	_____mood swings	_____stress management

Informed Consent for Treatment

Counseling is a joint effort involving, both, yourself, and/or your child and your counselor. The success or failure of counseling is a function of the efforts of both the counselor and the client(s) seeking the service. In general, the benefits of counseling may include increased insight, improvement in self-esteem, improvement in interpersonal relationships, relief of symptoms including decreased anxiety and/or depression, and improvement in your ability to maintain your daily level of functioning. (Specific problem areas/needs and counseling goals will be addressed with you or your child's counselor.)

It is possible that counseling may provide a temporary increase in you or your child's symptoms or stress level due to the need to focus on the problem areas.

Diagnostic assessment, with or without formal testing, is an important aspect of your or your child's treatment to aid in increasing knowledge of your or your child's personality and/or intellectual functioning as well as an aid in your or your child's progress in counseling.

From time to time, your counselor may consult with other counselors of River of Life Christian Counseling regarding a clinical matter. All counselors of River of Life Christian Counseling are bound by confidentiality. In the event that additional information needs to be obtained or your counseling services discussed with a third party, you will be asked to sign a release of information.
By signing this informed consent for treatment, you agree you have received River of Life Christian Counseling Handbook which, among other things, details information concerning your privacy rights and agree with the terms stated in the handbook.

I understand that I am financially responsible for all charges incurred. Payment (or co-payment for client's with applicable insurance) is due at time of each visit. I am aware that River of Life Christian Counseling requires a 24-hour cancellation notice and I will be billed 50% of the session rate if I do not keep an appointment and did not give this cancellation notice.

I hereby authorize the staff of River of Life Christian Counseling to use any or all procedures and treatments customarily employed in counseling, which may or may not include talk therapy, testing, biblio-therapy, prayer, and Scriptural instruction.

_____ I consent to receive mental health services.
Initials

I consent for my child, _____, to receive mental
_____ health services.
Initials

_____ As Guardian, I consent for, _____, to
receive
Initials mental health services

_____

Signature of Client/Parent/Guardian Date

_____

Signature of Counselor Date