

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: _____

EMERGENCY CONTACT (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 SUBSCRIBER: (please check one):

SELF SPOUSE 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):

<u>NAME</u>	<u>BIRTHDATE</u>	<u>GENDER</u>	<u>RELATIONSHIP</u>	<u>AT HOME?</u>
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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
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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 you, 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 and your counselor.)

It is possible that counseling may provide a temporary increase in your 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 treatment to aid in increasing knowledge of your personality and/or intellectual functioning as well as an aid in your 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.

_____ | consent to receive mental health services.

Initials

Signature of Client

Date

Signature of Counselor

Date