A Season For All Counseling

CLIENT INTAKE FORM

Counselor's Name: _____ Date ____/____/____

Client's Name _____ DOB ____ / ____ / ____

Parent/guardian name (minor clients) _____

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated

Home address: _____ City _____ State __ Zip ____

Home phone number _____ Work phone number ____ _____
Leave message at home ☐ Y ☐ N Leave message at work ☐ Y ☐ N

Cell phone number _____ Whose cell? _____

Your occupation_____ Employer's name _____

Address:_____

Referred by:_____

Medical conditions:_____
_____

Past medications and dosage: _____

Current medication and dosage: _____

Allergies:_____

Previous Therapy ☐ Y ☐ N Former Therapist _____
Was your previous therapy helpful ☐ Y ☐ N

What problems are you seeking counseling for now? _____
_____
Person who is financially responsible for today's visit _____
Billing address if different from client _____
Billing Phone Number: _____

Billing Email:(where invoices will be sent):_____

The counselor may discuss my case with the following people: _____
_____

Client's Signature _____ Date _____/____/____

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CONSENT TO TREATMENT AND CONFIDENTIALITY

I, ____________________, request counseling and/or therapy services from:
A Season For All Counseling, LLC   1850 Gates Kingman, AZ 86401

CONFIDENTIALITY EXPLANATION

This document serves as an understanding and agreement between you, the counselee and Jamie Hicks at A Season for All Counseling. Confidentiality is an important element of the therapy process. Your identity and ongoing work in therapy will be kept confidential with the following exceptions:

- I will 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 consults.

- If a court of law orders a subpoena of case records or testimony I will first asset "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 with your written permission or if a court denies the assertion of privilege and orders the release of records. Policy: Records are shredded after stopping services (one month from last visit)

- If I feel you are a threat to yourself or others, (If you are making suicidal or homicidal statements,) I may need to report these statements to your family and / or other appropriate mental health or law enforcements professionals.

- There are a broad range of event 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.

- Suspected elderly abuse is a reportable event.

  Note-text, email and any online counseling are all vulnerable to hacking, etc. and confidentiality cannot be strictly guaranteed. When using electronic communications, an attempt will be made to minimize the sensitive information discussed to further protect your privacy.

Waivers of Liability (please read carefully and initial each statement)

_____ By submitting signed forms and payment for counseling, I hereby acknowledge and understand the conditions set forth in this document and further release from liability A Season For All Counseling Services, LLC from a claim or litigation whatsoever arising from my participation in biblical encouragement counseling sessions.

_____ In consideration for receiving counseling from A Season For All Counseling, LLC I agree to release and waive any and all claims of any kind against the ministry, the staff, the pastoral/lay encouragers or any participating church, which may arise from, result out of, or be related to advice or encouragement received.

_____ I understand that all encouragement provided in this ministry is provided in accordance with the biblical principles adhered to by the pastoral licensing board known as the National Christian Counselors Association and is not necessarily provided in adherence with any local, state or national psychological or psychiatric association.

Additionally, it is important for you to know that your counselor is licensed by the National Christian Counselors Association as a Licensed Clinical Pastoral Counselor

_____ I agree that A Season For All Counseling, LLC reserve the right to consult with other counseling professionals or appropriate advisors/supervisors regarding counseling sessions and that any professional consultations will be held in the same level of confidentiality as all counseling sessions.

_____ By submitting signed forms and payment for counseling, I am stating that I have read and understand the contents of this waiver, and consent to and requests said counseling and biblical encouragement.

Client Responsibility _____ I understand that it is my responsibility to be open and honest with the counselor and that I must be willing to receive help and listen to sound Godly advice in order to recognize progress in my life.

Counselor Responsibility _____ I understand that the counselor has a responsibility to pray with me and for me, utilize sound Biblical and mental health principles, and give prayerful advice that may be difficult for me to accept during counseling sessions.

Signature: _____ Date: _____

Read carefully and initial each statement below

_____I agree to pay at the time of service the agreed upon amount per counseling session. If I have a current balance I will not be able to have another session until the previous session is paid in full. _____I understand that if I am a "no show" for an appointment, that I am to pay the agreed upon amount. _____I understand that if I desire to submit an insurance claim for counseling that I must pay the full amount for the counseling session up front and that I am not guaranteed reimbursement from my insurance carrier.

Please check any of the following symptoms or conditions you have had or are now experiencing.

CONDITION	Past	Present	CONDITION	Past	Present
Mood highs and lows	☐	☐	Insomnia (can't sleep)	☐	☐
Weight loss or gain	☐	☐	Excessive worries	☐	☐
Appetite changes	☐	☐	Difficulty concentrating	☐	☐
Drug usage	☐	☐	Hearing unseen voices	☐	☐
Cigarette smoking	☐	☐	Frequent loss of temper	☐	☐
Tobacco usage	☐	☐	Acting out in violence	☐	☐
Irritability	☐	☐	Frequent residence changes	☐	☐
Excessive stress	☐	☐	Frequent employment change	☐	☐
Crying spells	☐	☐	Bed wetting past age 6	☐	☐
Phobias or fears	☐	☐	Fire setting past age 6	☐	☐
Hallucinations	☐	☐	Blaming others frequently	☐	☐
Confusion	☐	☐	Lack of sexual desire	☐	☐
Low of self esteem	☐	☐	Spiritual confusion	☐	☐
Compulsive behaviors	☐	☐	Thoughts of suicide	☐	☐
Depression	☐	☐	Inability to comprehend reading	☐	☐

CONDITION	Past	Present	CONDITION	Past	Present
Extreme nervousness	☐	☐	Inability to comprehend math	☐	☐
Lack of motivation	☐	☐	Inability to express yourself	☐	☐
Excessive drinking	☐	☐	Involvement with the occult	☐	☐
Indecisiveness	☐	☐	Use of Pornography	☐	☐
Loss of memory	☐	☐	Physical abuse of children	☐	☐
Fantasizing	☐	☐	Sexual abuse of children	☐	☐
Sexual abuse from others	☐	☐	Physical abuse of others	☐	☐
Physical abuse of others	☐	☐	Excessive sexual activity	☐	☐
Abortion	☐	☐	Drug Use / Addiction	☐	☐
Divorce	☐	☐	Loss of loved one	☐	☐

Please give a brief explanation that will clarify the items you checked above: (use back if necessary)

_____
_____
_____
_____
_____
_____

Do you attend church regularly? ☐ Yes ☐ No If yes, Name of Church and Pastor _____ If you were to die tonight, do you know for certain you would go to Heaven? ☐ Yes ☐ No ☐ Unsure

Background Information

1. How long has it been since you had a complete physical examination? _____

2. Other physical/emotional disorders the therapist should be aware of:
_____

PERSONAL HISTORY / PROBLEM EVALUATION

BASIC PROBLEM IDENTIFICATION
(Briefly answer the following)

- DESCRIBE THE PROBLEM THAT BRINGS YOU HERE TODAY:

- WHAT HAVE YOU DONE ABOUT IT SO FAR?

- WHAT DO YOU HOPE TO GAIN FROM THIS COUNSELING?

- WHAT CIRCUMSTANCES HAVE LED TO YOU COMING HERE TODAY?

- IS THERE ANY OTHER INFORMATION THAT YOU THINK THE COUNSELOR SHOULD KNOW?

Crisis

In the event of a crisis please call 1-877-756-4090 OR 988. We are not a crisis intervention agency. We only allow for regular scheduled appointments

Cancellation Policy

We agree to (and ask that clients) maintain responsibility in relation to appointment times. Any client who does not show up or cancels without 24 hours' notice, will be charged to the client (1) For the first incident, a $50.00 fee, and (2) Second occurrence and any incidents thereafter is full session price. Any charges would need to be paid in full prior to rescheduling.

Discharge and Termination

_____ The client has the right to terminate the counseling relationship at any time. However, it is in the client's best interest to discuss and plan for discharge with their counselor.

Counseling may be terminated for consistent failure to complete assignments, failure to pay fees, and failure to consistently show for scheduled appointments.

If there is a lapse in treatment for 1 month, unless arrangements have been made with your counselor, you will automatically be discharged from treatment.

Signature: _____ Date: _____