TH MINISTRIES CHRISTIAN COUNSELING SERVICES

WEBSITE: WWW.THMINISTRIES.ORG

Date: _ _ / _ _ / _ _ _ _   Who referred you?________________________________   Age

Name: ____ Gender: Male Female DOB:_____/___/____

Address:____ City/State/Zip: ______________________________

Home Phone: ____ May we leave a message here? Yes No

Mobile Phone: ____ May we leave a message here? Yes No

Work Phone: ____ May we leave a message here? Yes No

Occupation: ____ Employer: ____

Avg. Hours/Week: ____ Length of Time at Current Job: _________________________

Email: ____ May we email this address? Yes No

Highest Degree(s) Earned: ____________________________________ School: ____

Who do you currently live with? *Check all that apply.*

Alone Spouse Parent(s) Father Mother Boyfriend Girlfriend Other:_______________________________________

MARRIAGE-FAMILY INFORMATION:

Spouse's Name: ____ Age: _______

Spouse's Address: *SAME* or ____

Home Phone: *SAME* or ____ May we leave a message here? Yes No

Email: ____ May we email this address? Yes No

Is your spouse willing to come for counseling? Yes No

Date of Marriage: ______/_____/_______ Your Age When Married: Husband ________________ Wife ______________

How long did you know your spouse before marriage?____

Length of Steady Dating: ______________________________________ Length of Engagement: ______________________________

Give *brief* information about any previous marriages:

EX-SPOUSE'S NAME	YEAR MARRIED	LENGTH OF MARRIAGE	REASON FOR DIVORCE	# OF KIDS

Give *brief* information about your children:

NAMES OF CHILDREN	AGE	MALE	FEMALE	DECEASED	LIVING	SPECIAL CONDITION

SPIRITUAL/RELIGIOUS INFORMATION:

Church Name: ____________________ City: ____________________

Are you a member? Yes No Number of Years as Member: __________ Average Monthly Attendance: __________

Are you a part of a Sunday school class? Yes No Are you part of a home/small group Bible study? Yes No

What are you learning through sermons and Bible studies at your church?: ____________________

Do you consider yourself a religious person Yes No Explain: ____________________

Please list any ministry involvement: ____________________

Spouse's Church Attendance (Times per Month):__________

Do you and your spouse openly discuss and encourage one another in your faith?: Yes No

HAVE YOU RECEIVED JESUS CHRIST PERSONALLY AS YOUR SAVIOR? Yes No Uncertain Not sure

Have you been baptized? Yes No When?____________________

If applicable, what is the religious background of your spouse?: ____________________

Do you pray to God? Yes No How often? ____________________

What do you pray about?: ____________________

How would you define the Gospel and what it means to be a Christian?: ____________________

Do you read the Bible? Yes No How often?____________________

Do you have personal devotions? Yes No How often?____________________

Describe your personal devotions: ____________________

Do you have family devotions? Yes No How often?____________________

Describe your family devotions: ____________________

Please note any changes to your spiritual life recently:____________________

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HEALTH INFORMATION:

Have you had counseling before? Yes No Have you seen a psychiatrist before? Yes No Currently

Give *brief* explanation of your experience *(use the back of this page if necessary or you need more space)*:

AGE	DURATION	COUNSELOR/CENTER	ISSUE(S)/TOPIC(S)/DIAGNOSIS	YOUR EVALUATION OF COUNSELING

Approximately how many hours of sleep do you get each night?____________________

When do you normally go to bed?_______________ fall asleep?____________ wake up?_____________ get out of bed?______________

Average sleeping hours per night? _________________

Describe any recent changes in sleep habits: ____

State of Current Health? Very Good Good Average Declining Other: ____________________________

Date of Last Medical Examination: ______________________________ Results: ______________________________

List an current illness, injury, or disability: ____

____

Are you presently taking any medication? Yes No Prescribing Doctor: ______________________________

List your current medications *(use the back of this page if necessary)*:

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED FOR…	DATE BEGAN TAKING

Have you used drugs for other than medical purposes? Yes No When?______________________________

What?: ______________________________________ Amounts/Dosage?: ______________________________

Do you consume alcohol? Yes No How much? ______________________________

Describe your eating habits or changes in appetite:______________________________

Describe your exercise routine: ____

Please indicate any of the following physiological symptoms that apply to you:

SYMPTOM	YES	SYMPTOM	YES	SYMPTOM	YES
Headaches		Difficulty Breathing		Rapid Heart Rate	
Visual Trouble		Tension		Dizziness	
Weakness		Fatigue		Pain	
Sleep Trouble		Change in Appetite		Other *(use the back)*	

MEDICAL/HEALTH INFORMATION:

How would you rate your current health? Excellent _________________Good ___________ Fair ___________Poor _

Date of last physical exam: _________________________ Physician: ____

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems):

Yes No if yes, please explain: ____

Describe any physical problem you or a member in your household have which require medical or physical care:

____

Have you ever had surgery? If yes, for what reason? ____

Are there chemical substance abuse issues in your family? Yes ___ No ____ Who? ____

If clean/sober, for what length of time? ____

Have you ever been hospitalized for mental illness or substance abuse? Yes _____________ No ______________

If yes, for what specific reason and where? ____

Have you ever participated in counseling before? Yes __________ No _______ If so, when and why? ______________________

____ Name of Therapist: ____

Please indicate which of the following areas are currently problems for you. Check all that apply:

Under too much pressure/feeling stressed
Excessive anxiety or worry
Feeling lonely
Angry feelings
Concerns about finances
Feeling "numb" or cut off from emotions Angry outbursts
Excessive fear of specific places/objects
Difficulty making friends
Feeling as if you'd be better off dead
Feeling that people are "out to get you"
Feeling manipulated or controlled by others
Difficulty making decisions
Loss of interest in sexual relationship
Feeling sexually attracted to members of your own sex
Concerns about physical health
Loss of appetite/increased appetite
Lacking self confidence

Recent significant weight gain/loss
Use of alcohol
Use of non- prescription/prescription drugs
Feeling distant from God
Hallucinations
Inability to concentrate while at school/ work Crying spells
Nightmares
Loss of interest in usual activities/lack of motivation
Obsessions or compulsions with specific activities or thoughts
Inability to control thoughts
Feeling trapped in rooms/buildings
Hearing voices
Blackouts or temporary loss of memory
Sleeping too much or too little

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Any other information that you feel is important to share that is not covered:

____

____

____

____

____

____

____

ADDRESS AND CONTACT INFORMATION:

Mailing Address ____

City ___________________________ State _________ Zip ______________

Phone: Home _____________ Cell _____________ Work ____________________________

Second cell phone __________________________belongs to? _____________________

Client email address: ____

Emergency Contact: Name _____________________ Relationship ____________Phone _____________

For confidentiality, in order to confirm and/or change appointments, may we contact you at:

Check all that apply: Home _______ Work _____ Cell _____Text ______Email ______

Please list preferred days/times for your appointment availability: _________________________

____

RELIGIOUS BACKGROUND:

Religious Affiliation: ___________________________________ Active________or Inactive ________

Do you attend a local church? Yes _______ No_____ If yes, name of church: ______________________

How significant is your religion to your everyday life? ______________________________

____

____

____

____

____

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PLEASE COMPLETE THE FOLLOWING:

My ambition in life is to: ______

What really hurts me is: ______

I get nervous when: ______

I wish I could lose my fear of: ______

What I wish I could change about myself is: ______

My *best* childhood memory: ______

My *worst* childhood memory: ______

My biggest regret is: ______

My greatest achievement is: ______

To be happy I need: ______

I would do anything for: ______

I often wonder why: ______

I think God sees me as: ______

One word to describe myself is: ______

1. Please describe the current problem, as you understand it: ______

2. What have you done about it (*most* effective and *least* effective)?: ______

3. Other than counseling, what help are you seeking?: ______

4. Please describe any family history (the family that you grew up in), which might be pertinent to the concerns that you bring to counseling (your relationship with your parents, their relationship with each other, significant losses or events): ______

5. What are your expectations in coming here?: ______

6. What, if any, are your concerns about coming to counseling?: ______

7. What do you believe you will have to change to see the progress you desire: ______

8. Is there any other information we should know?:

9. Have you ever dealt with abuse of any kind that you need counseling for? (Sexual, substance, domestic) Please specify______

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PROFESSIONAL DISCLOSURE AND CONFIDENTIALITY FORM

Confidentiality is an important aspect of the counseling process, and we will carefully guard all of the information you disclose. However, TH Ministries Counseling Services does not guarantee absolute confidentiality. Your counselor reserves the right to consult with other counselors, pastors/elders, for the purpose of providing the highest level of care towards your wellbeing.

There are times when counseling information may be shared outside of our sessions. Those exceptions include: (1) known or suspected child or elderly abuse of any kind; (2) the intent to take criminal actions or violence against another person; and (3) active suicidal thoughts or intentions; (4) you sign a written release.

If you are suicidal during the course of your counseling, it is imperative that you talk with your counselor about these matters. By initialing this form you are indicating that you agree to share any suicidal thoughts or intentions with your counselor at any time they arise, and that you would seek medical care if you become suicidal in the course of your counseling.

In the case of marriage or family counseling, there is limited confidentiality, meaning the confidentiality belongs to the relationship and not to the individual.

As a ministry, **we** reserve the right to involve the church where you hold membership for the purpose of referrals and cooperative pastoral care. The persistent refusal to renounce a particular sin may require the disciplinary involvement of your church.

Confidentiality for counseling at TH Ministries Counseling Services, as a church ministry, is defined by pastor-parishioner privilege and, therefore, our counselors operate as agents of the church (pastors/ministers) not agents of the state (licensed counselors). This means c**ounseling conversations are inadmissible in a court of law** in the same way as conversations with a priest in a confessional booth. If your counseling subject requires professional representation in a court setting by a counselor, **TH Ministries Christian Counseling Services** is not the best fit for your needs.

Your counseling records (including intake forms, session notes, and other relevant counseling documents) will be maintained on secure digital platforms. While we strive to ensure the confidentiality of your records, we cannot guarantee their protection from unauthorized use or should those platforms become compromised beyond our control.

Initial here if you understand and agree with this Confidentiality Clause:

WAIVER OF LIABILITY:

In seeking counseling, you must acknowledge your understanding of the following conditions and further release **TH Ministries Christian Counseling Services**, from any legal liability, claims, or litigation arising from your participation in this **voluntary** organization and ministry:

Initial here if you understand and agree with this Waiver of Liability:

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CONSENT TO COUNSEL:

I, ____ *(print name)* grant permission for **TH MINISTRIES CHRISTIAN COUNSELING SERVICES,** to render biblical counseling services to me and the names listed below *(please include the names of those who may be involved in the counseling process):*

____ ____

____ ____

____ ____

I also understand that **TH MINISTRIES CHRISTIAN COUNSELING SERVCIES** may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, or for other similar issues.

PLEASE SIGN BELOW TO INDICATE THE FOLLOWING:

1. You have read the policies in this document.
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into biblical counseling of your own will.

____ ____

Counselee *Signature* *Date*

____ ____

Signature of ***Parent or Guardian*** *(if applicable)* *Date*

____ ____

Counselor's Signature *Date*

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