ABUNDANT LIFE RECOVERY

• Please fill out all four pages as completely as possible and **read and sign the last page**. You may write on the back as well. Bring the form to your first appointment.

• At the beginning of your first appointment, please have the intake form filled out, and have your check, cash or credit card information available for services.

Date: _____

Client**:** _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____

What phone number would you like me to use to contact you? _____

Marital Status: ☐Single, ☐Married, ☐Separated ☐Divorced, ☐Widowed How long? _____

Have you been married before? ☐Y ☐N Explain: _____

_____

If Single, are you dating? ☐Y ☐N If no, do you want to start dating someone? ☐Y ☐N

If yes, mark appropriate box: ☐for fun, ☐exclusive, ☐multiple people, ☐for marriage

Describe your relationship if in one: _____

_____

Do you have children? ☐Y ☐N

Name_____ Age_____ At Home?_____

Name_____ Age_____ At Home?_____

Employer: _____ Employer Phone _____

Occupation: _____Number of Years: _____

Do you enjoy your work? _____

Would you like to change your work? _____

Hobbies: _____

_____

What brought you to counseling? _____

_____

_____

What are your goals for counseling and how long do you think it will take to meet them?

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

Please describe any health/medical problems you have: _____

_____

Current treatment or medications you are taking? _____

_____

Have you been hospitalized for substance abuse or any other psychiatric disorder?
☐Y ☐N Explain:_____
Please list any treating Psychiatrist name & number _____
Date of last physical exam? ___/___/_____ = ☐Excellent ☐Good ☐Poor ☐Bad

Symptoms - Check on the line provided

____ Jealousy	____ Financial Issues	____ Feelings of Guilt
____ Abandonment	____ Identity Crisis	____ Anger/Rage
____ Depression	____ Intimacy Problem	____ Shame
____ Parenting Problems	____ Affair(s)-Emotional/Sexual	____ Phobias
____ Lack of Communication	____ Compulsive Behaviors	____ Anxiety
____ Spiritual Issues	____ Conflict Avoidant	____ Alcohol/Drug Abuse
____ Panic Attacks	____ Sexual Problems	____ Moody
____ Uncontrollable Fears	____ Suicidal Thoughts	____ Nightmares
____ Controlling Behaviors	____ Eating Issues	____ Low Self-Worth
____ Parent/Child Conflict	____ Phase of Life Problem	____ Confusion

Have you ever contemplated suicide or attempted it? _____When? _____
Have you ever been violent with your partner, child or someone else or has someone been violent with you? ☐Y ☐N Explain: _____
_____
Briefly describe any major crisis in your life: _____
_____
_____
_____
Do any of the following apply to you or your family members including grandparents? If so list the relationship on the line with short description:

Issue	**Names and relationship to client**	**Treatment**
Alcohol abuse		
Drug abuse		
Suicide		
Physical abuse		
Eating disorder		
Sexual abuse		
Sexual addiction		
Emotional abuse		
Divorce		
Adoption		
Mental illness		
Chronic physical illness		

Describe any past or current addictions of either parent and relapses of alcohol, drugs, medications, food, sexual addiction, gambling, gaming, or other:

Dates of use to sobriety	Substance(s) Abused	Describe Abuse	Treatment Received

Have you ever been in counseling before? ☐Y ☐N Explain: _____

If yes, why did you terminate? _____

Who referred you? _____ May I thank them? ☐Y ☐N

Please list emergency contacts: Name:_____ (#): (____)_____

Name:_____ (#): (____)_____

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CONSENT TO TREATMENT

• I consent to individual coaching or pastoral, spiritual and addictions counseling.

• Dependent on Client's beliefs, I understand Shifra's style of coaching and counseling may incorporate Judeo-Christian faith based biblical perspectives, values and truths to achieve optimum results.

• _____**Initial if you agree to prayer** with Shifra and give permission to pray for me or leave blank if you do not want Shifra to pray with you.

• I understand Shifra is a board-certified life coach, and pastoral, spiritual and addictions counselor and that Shifra is not a psychologist, psychotherapist or physician, and as such, will not testify in any litigation. In the unlikely event of subpoena, Shifra will exercise her right to fully invoke the clergy/client confidentiality privilege for the sole purpose of protecting her position as clergy and the Sacred Trust of those she counsels.

• I understand if Shifra feels like your issues are beyond of the scope of her expertise, she will work with you in seeking an appropriate referral that will better meet your needs.

CONFIDENTIALITY

• I understand that everything discussed in counseling is confidential. The only exception to this is in the case of the client's endangerment, such as suicidality, endangerment of others, such as a genuine threat to severely harm another person, and in the case of child and/or elder abuse. I understand my counselor is obligated legally to report to authorities and or take protective measures should it become apparent there are any of these exceptions.

TREATMENT POLICIES

• I agree I am responsible for the full session payment per 60-minute session at the time of treatment payable by credit card, check or cash.

• I understand that my fee is $____ per session and all payments are due at the end of each session. I agree to pay my counselor after my session.

• I understand that the full payment is due at the time services are rendered and I will receive a monthly receipt for services rendered.

• I understand if I am over 15 minutes late for an appointment, the session is considered a "no show" and I **will be charged for the full session**.

• If you have a non-life threatening emergency, you call the counselor and your call will be returned as soon as the counselor is available. If you need to talk **more than ten minutes** and the counselor has time, you can schedule a phone appointment and will be charged for that session.

• If you have an emergency please call 911 directly.

• If a check bounces, **you will be charged a $25.00 service charge**. After two times, you need to pay in cash.

I have read and understand and agree to the "Consent to treatment", "Confidentiality" and "Treatment Policies".

_____	_____	_____
(Print Client's Name)	(Client's Signature)	(Date)