



Discovery Counseling

A Non-profit Ministry Providing Biblical Counseling

Counselor : _____

Date : _____

Confidential Client Information Form

GENERAL INFORMATION

Full Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

Nick Names: _____

Sex: Male Female

Age: _____

Date of Birth: _____

Race: White Black Latino Asian Other: _____

Referred by: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code : _____ May we send mail here: Yes No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code : _____ May we send mail here: Yes No

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

Email Address: _____ May we send a message here: Yes No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked per Week: _____

Annual Salary: \$0 to \$10,000 \$20,001 to \$40,000 \$50,001 to \$60,000 \$80,001 to \$100,000

\$10,001 to \$20,000 \$40,001 to \$50,000 \$60,001 to \$80,000 More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: 9 10 11 12 GED College: 1 2 3 4 Other: _____

Are You Currently in School: Yes No. If Yes, What Level: _____ Degree Pursuing: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____)_____

Address: _____ City: _____ Zip: _____

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): _____

Are You Currently Receiving Medical Treatment: Yes No. If Yes, Please Specify: _____

List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments you've had (Use Back if Necessary):

MEDICATION INFORMATION

List All Current Medications You are Taking, Including those you Seldom Use or Take Only as Needed (Use Back if Necessary)

Medication	Dosage	Improves, Prevents or Controls	Treating

Are You Taking These Medication(s) According to Your Doctor's Recommendations: Yes No.

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to you Presently or in the Recent Past:

- | | | |
|--|--|--|
| Headaches..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Dizziness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Stomach Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Visual Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Sleep Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Trouble Relaxing..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Weakness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Tension..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Rapid Heart Rate..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Difficulty Breathing..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Intestinal Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Hearing Noises..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Change in Appetite..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Tiredness..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Pain..... <input type="checkbox"/> Past <input type="checkbox"/> Present |
| Hearing Voices..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Seeing Things..... <input type="checkbox"/> Past <input type="checkbox"/> Present | Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present |

Your Height: _____ Your Weight: _____ How has Your Weight Changed in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems that Apply to you and/or Your Family:

- | | | |
|--|--|--|
| Stress..... <input type="checkbox"/> You <input type="checkbox"/> Family | Nervousness..... <input type="checkbox"/> You <input type="checkbox"/> Family | Anxiety..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Panic..... <input type="checkbox"/> You <input type="checkbox"/> Family | Unhappiness..... <input type="checkbox"/> You <input type="checkbox"/> Family | Depression..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Guilt..... <input type="checkbox"/> You <input type="checkbox"/> Family | Apathy..... <input type="checkbox"/> You <input type="checkbox"/> Family | Terminal Illness..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Recent Death..... <input type="checkbox"/> You <input type="checkbox"/> Family | Grief..... <input type="checkbox"/> You <input type="checkbox"/> Family | Hopelessness..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Inferiority Feelings..... <input type="checkbox"/> You <input type="checkbox"/> Family | Defective Feelings..... <input type="checkbox"/> You <input type="checkbox"/> Family | Loneliness..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Shyness..... <input type="checkbox"/> You <input type="checkbox"/> Family | Fears..... <input type="checkbox"/> You <input type="checkbox"/> Family | Friends..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Marriage..... <input type="checkbox"/> You <input type="checkbox"/> Family | Communication..... <input type="checkbox"/> You <input type="checkbox"/> Family | Physical Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Emotional Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family | Verbal Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family | Sexual Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Temper..... <input type="checkbox"/> You <input type="checkbox"/> Family | Anger..... <input type="checkbox"/> You <input type="checkbox"/> Family | Aggressiveness..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Bad Dreams..... <input type="checkbox"/> You <input type="checkbox"/> Family | Concentration..... <input type="checkbox"/> You <input type="checkbox"/> Family | Racing Thoughts..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Unwanted Thoughts..... <input type="checkbox"/> You <input type="checkbox"/> Family | Memory..... <input type="checkbox"/> You <input type="checkbox"/> Family | Loss of Control..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Impulsive Behavior..... <input type="checkbox"/> You <input type="checkbox"/> Family | Self-Control..... <input type="checkbox"/> You <input type="checkbox"/> Family | Compulsivity..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Sexual Problems..... <input type="checkbox"/> You <input type="checkbox"/> Family | Pregnancy..... <input type="checkbox"/> You <input type="checkbox"/> Family | Abortion..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Legal Matters..... <input type="checkbox"/> You <input type="checkbox"/> Family | Trauma..... <input type="checkbox"/> You <input type="checkbox"/> Family | Eating Problems..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Drug Use..... <input type="checkbox"/> You <input type="checkbox"/> Family | Alcohol Use..... <input type="checkbox"/> You <input type="checkbox"/> Family | Trouble with Job..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Career Choices..... <input type="checkbox"/> You <input type="checkbox"/> Family | Ambition..... <input type="checkbox"/> You <input type="checkbox"/> Family | Making Decisions..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Children..... <input type="checkbox"/> You <input type="checkbox"/> Family | Being a Parent..... <input type="checkbox"/> You <input type="checkbox"/> Family | Finances..... <input type="checkbox"/> You <input type="checkbox"/> Family |
| Recent Loss..... <input type="checkbox"/> You <input type="checkbox"/> Family | Disaster..... <input type="checkbox"/> You <input type="checkbox"/> Family | Other..... <input type="checkbox"/> You <input type="checkbox"/> Family |

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1= Very Little Distress; 10=Extreme Distress)

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: Yes No. Have You Experienced Them in the Past: Yes No

Have You Ever Attempted Suicide: Yes No. If Yes, When & How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: Yes No.

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?): _____

Why Have You Decided to Come for Counseling Now: _____

What Do You Hope to Gain or Change by Coming for Counseling: _____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back if Necessary)

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

What Words Would You Use to Describe Yourself: _____

If God Were to Describe You, What Would He Say: _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

Complete the Following Thought: God is _____

Do You Regularly Attend a Place of Worship: Yes No. If Yes, Where: _____

Signed: _____ Date: _____

Discovery Counseling

A Non-profit Ministry Providing Biblical Counseling

Welcome to Discovery Counseling where we seek to offer biblically based, Christ-centered, counseling/guidance addressing many common issues of life. Our team consists of lay counselors, staff ministers, and staff counselors who have been called into the helping ministry of biblical counseling and guidance.

Qualifications of counselors: Our Christian Counselors have years of experience ministering to the personal needs of individuals. Because of the biblical and spiritual nature of this type of ministry we train our staff for the ministry of biblical counseling and guidance. **The counselors, lay counselors and ministers do not hold professional licenses or certifications. No staff, paid or volunteer, will render any legal or medical opinions or advice.**

Our Approach: Discovery Counseling employs a method of biblical counseling and guidance utilizing spiritual/biblical principles. In this kind of discipleship process, the Holy Spirit, not the counselor, is the agent of individual change. Our goal is to present God's plan for victory in the midst of one's circumstances.

Limitations of Confidentiality: It is understood (and agreed) that all statements, whether written or verbal, are of a confidential nature and ethically cannot be disclosed without written consent. The following exceptions will result in confidentiality being waived:

1. We reserve the right to report child abuse or suspicion of child abuse of any type to the proper authorities and/or the right to cause a report of child abuse to occur.
2. We reserve the right to disclose to the appropriate person, agency or civil authorities any harm that a person may attempt or desire to do to one's self or to others.
3. To insure the highest quality discipleship process, as a rule your counselor/lay counselor will consult with their supervisor regarding your session(s).
4. We reserve the right to consult with other professionals regarding your sessions, upon written consent.

Resolution of Disagreements: If a dispute should arise between the person receiving ministry and the counselor, lay counselors and minister regarding the counseling session, one should bring this dispute to the attention of the Director of Discovery Counseling.

Waiver of Liability: In consideration for receiving biblical counseling and guidance from Discovery Counseling, the person receiving counseling agrees to release and waive any and all claims of any kind against the counselor, staff, lay counselor, minister of Discovery Counseling, which may arise from, result out of, or be related to their counsel or conduct.

Fees: Fees for biblical counseling/guidance are payable to Discovery Counseling, A Nonprofit Corporation.

Late Policy: Counselees more than 15 minutes late to their scheduled appointment will be asked to re-schedule. It is to the counselee's advantage to be timely in order to receive the full benefit of the scheduled appointment.

Cancellations or Reschedules: In the event you need to reschedule or cancel an appointment we ask that you call 24 hours in advance. This allows us to reschedule others who are waiting.

Session Length: A typical session is 50 minutes in length.

Referrals: When issues arise beyond the staff's scope of expertise, referral is suggested. In suggesting referral to outside agencies, Discovery Counseling does not provide endorsement or guaranteed results in overcoming issues. The counselee takes full responsibility for seeking out the proper treatment. Therefore, it is incumbent upon the counselee to seek out the desired "fit" regarding Professional Christian Counsel.

Third Party Involvement: Discovery Counseling is not a community mental health clinic. It does not operate under guidelines that may be associated with other community counseling organizations. All lay counselors, staff counselors and ministers, are employees and/or volunteers of Discovery Counseling should be expected to conform to the beliefs, goals and guidelines established by the leadership of the same.

The information contained herein and the following data sheets are true and complete to the best of my knowledge. I have carefully read, understand, and agree to all of the above terms and conditions.

Counselee signature

date