STORYLINE
BIBLICAL COUNSELING

COUNSELEE FORMS

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BIBLICAL COUNSELING AGREEMENT

Thank you for your interest in Christ-centered biblical counseling and for giving us an opportunity to serve you. We look forward to helping you find God's help and hope for the problems you are facing. The following information will help you further understand our ministry and will serve as an agreement between us.

I. General Comments:

Your counselor is an institutionally trained and certified biblical counselor with The Southern Baptist Theological Seminary and the Association of Certified Biblical Counselors (ACBC), not a licensed psychologist, therapist, or psychiatrist, and offers Christ-centered, biblically-based counseling, not psychological counseling. If you have significant legal, financial, medical, or other technical questions, you should seek advice from an independent professional. Your counselor will seek to help you apply God's Word to your life, based on your counselor's understanding of God's Word.

Your counselor may have one or more church members or leaders present in the sessions to assist them, observe them for ministry training purposes, or to serve you as mentors. These individuals will observe the same standards of care and confidentiality as your counselor.

You or your counselor may choose to discontinue counseling at any time, without explanation.

II. Confidentiality and Legal Concerns

Confidentiality is an important aspect of the counseling, and your counselor will carefully guard the information you entrust to him. We desire as much as possible to protect your privacy.

At the same time, you must realize that this confidentiality is only within the limits of biblical and civil law. Your counselor cannot guarantee absolute confidentiality in every situation. For example, to ensure that you are receiving consistent counsel and support, your counselor might need to discuss your situation with appropriate leaders of your local church, or, in some cases, with your attorney, if you have one. Furthermore, they might need to divulge information to appropriate civil authorities if there is indication that you or someone else might otherwise be harmed. In counseling minor children, your counselor might need to divulge information to parents or legal guardians.

Your counselor also asks you to agree not to discuss our communications with people who do not have a necessary interest in the counseling or conciliation process. In addition, where your situation might involve legal issues, you must agree to treat all dealings with them in regard to this counseling as settlement negotiations, which means they will be inadmissible in a court of law or for legal discovery. Furthermore, you must agree that you will not try to force your counselor to divulge any information acquired during the counseling process or to testify in any legal proceeding related to the process.

Agreement by Counselee: If you have any questions about the above matters, please talk with your counselor. If you agree to these terms, please sign below and return this sheet to your counselor before your first meeting.

I have read and understand the above guidelines and find them acceptable.

Name _____ Sign _____ Date _____

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PROBLEM OVERVIEW

This brief overview helps you clarify your understanding of your problems or conflicts, and your desires and expectations for meeting with a Storyline Counselor. It also helps us gain an initial understanding of you and your situation. Don't be overly thorough or precise; you will have time during our discussion to explain and expand on what you have written. Your counselor will treat your answers as confidential (per our Agreement form); you need not share them with your spouse or others.

1. Briefly state in your own words the problem(s) or conflict(s) you are facing:

2. For how long have you been facing these problems?

3. What have you done so far about these problems?

4. How might you like your counselor to try to help you?

5. What issues or questions do you want to have resolved or answered?

6. As you see yourself, what kind of person are you? How might you describe yourself?

7. List any other information about you or the problem(s) that might be helpful to know:

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PERSONAL INFORMATION

Name: _____ Date Of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

Phone Number: _____ E-Mail: _____

How You Heard
About Storyline: _____

MARITAL STATUS/HISTORY

Check All That Apply: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Your Present Marriage (If Applicable)

Spouse's Name: _____ Age: _____ Occupation: _____

Date of Marriage: _____ Years Married: _____

If you and your spouse have ever separated, give dates and circumstances: _____

_____

Rate your marriage (circle: 0 terrible, 5 excellent): 0 1 2 3 4 5. What might make it better? _____

_____

If applicable, list the name(s) of your children, their ages, and where they live: _____

_____

If applicable, list previous marriage or relationships that produced children: _____

_____

Has your spouse been previously married? _____ How many times? _____

OCCUPATIONAL STATUS/HISTORY

Education (last level completed) _____ School/Institute _____

Occupation _____ Name of Company _____ City/State _____

Years there _____ Does your present work satisfy you? Explain: _____

_____

What other positions have you held in the past? _____

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FAMILY HISTORY

Parents: Name Age Where They Live Marital Status Occupation

Father:

_____

Mother:

_____

Guardian: _____ Dates: _____

Brothers/Sisters: (List in order from oldest to youngest; include yourself in that order):
Name Bro/Sis/Step Age Where They Live Marital Status Occupation

_____

_____

_____

_____

_____

Family "Climate": Describe your home life during your childhood and teen years: _____

_____

_____

Indicate any problems you experienced as a child or teen:

Family problems ___ School problems ___ Emotional/behavior problems ___ Legal problems ___ Medical problems ___
Social problems ___ Drug/alcohol problems ___ Other: _____

Psychological Problems: Have you, or any parent or brother or sister, been hospitalized or received professional help for

"psychological" problems? Specify person, dates, and problem: _____

_____

RELIGIOUS STATUS/HISTORY

Past Denominational Background _____ Present Denom. Preference _____

Church Presently Attending _____ City & State _____

Member: Yes No If "No," why? _____ Average # of times per month you attend _____

Pastor _____ Phone or Email _____ Permission to contact him: Yes No

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RELIGIOUS STATUS/HISTORY CONTINUED...

Do you believe in God? Yes No Unsure

Do you consider yourself "saved?" Yes No Unsure Don't understand the term

How frequently do you pray? Often Occasionally Rarely Never

How frequently do you read the Bible? Often Occasionally Rarely Never

What is your view of the Bible? _____

Have you come to the place in your spiritual life where you know for certain that if you were to die today you would go to heaven? Yes No Unsure

Suppose you were to die and stand before God and he were to say to you, "Why should I let you into my heaven?," what do you think you might say to God? _____

_____

Why do you desire Christ-centered, biblical counseling? _____

_____

Explain any recent changes in your religious life: _____

_____

MEDICAL STATUS/HISTORY

Rate your health: Very Good __ Good __ Average __ Poor __ Recent Problems? _____

Date of last medical exam: _____ Report _____

Your Physician _____ City & State _____

List any prescription medications you take:

Medication	Treatment for	When began	Daily dosage	Prescribing Physician

_____

_____

_____

List over-the-counter medications you currently take (diet pills, laxatives, birth control pills, allergy medicines, aspirin, etc.):

_____

List any surgeries that required anesthesia:_____

Average daily caffeine consumption? (coffee, tea, chocolate, stimulants, caffeinated soft drinks, etc.): _____

_____

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MEDICAL STATUS/HISTORY CONTINUED...

How often do you drink alcoholic beverages? Often Occasionally Rarely Never

How often do you struggle with the temptation to use illegal drugs? Often Occasionally Rarely Never

Average # of hours of sleep each night? ____ Is it restful? _____

Describe any recent changes in your sleep patterns: _____

Please check off any physical problems you have had:

Heart problems ___	Hypoglycemia ____	Menstrual irregularities ___
Liver problems ___	Lung Problems ____	Hallucinations ____
Kidney Problems ___	Allergies _____	Change in sexual drive ____
Head injury/concussion ___	Cancer ___	Problems walking ___
Stroke ____	Incoordination ___	Unusual hair loss ___
Seizures ____	Anorexia or Bulimia ___	Rashes ___
Brain Tumor ____	Visual Problems ____	Memory Problems ____
Multiple Sclerosis ___	Sensory distortions ____	Episodic disorientation ___
Parkinson's Disease ___	Weakness ____	Personality change ____
Blackouts ____	Fatigue ____	Deja Vu ___
Amnesia ____	Heat/cold sensitivity ___	Changes in consciousness ___
Tremors ____	Bowel/bladder problems ___	Headaches ____
Thyroid dysfunction ___	Nausea or vomiting ___	Dizziness ____
Diabetes ___	Recent weight change ____	Stiff neck ___
High Blood Pressure ___	Impotence ___	Physical changes ___
Constant Hunger ___	Food cravings ___	Fever ___
Pneumonia ___	Speech Problems ___	OTHER? _____

Have you or others noticed any changes in your personality (anger, mood swings, withdrawal, etc.), your thinking and memory, or your work habits? _____

_____

LEGAL ACTIONS (IF APPLICABLE)

If you have talked with an attorney about your problem, or intend to, please provide the following info:

Attorney _____ Firm _____ Address _____ Phone _____

Date and purpose _____

Has a legal action been filed or is one likely to be filed in this situation? No Yes (If yes, give dates/describe action below.)

_____

_____