Christian Counseling Services
Client Intake Form

Name: _____ **Today's Date:** _____

DOB _____ **Age** _____ Is client under 18 years of age? Yes ☐ No ☐

Name of Person filling out this form and reason: _____

_____

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____

Mailing Address (if different): _____

Phone: (C) _____ (H) _____ (W) _____

Email: _____

May we leave a voice/text message? Yes ☐ No ☐ If yes, by ☐ cell ☐ home ☐ work ☐ email
May we send you an appointment reminder? Yes ☐ No ☐ If yes, by ☐ text ☐ v-mail ☐ email

Employer: _____ **Occupation:** _____

Are you a student? Yes ☐ No ☐ If yes, name of school: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Referred by: _____ May we send them a thank you? Yes ☐ No ☐

Presenting Problem/Issues

Briefly describe the problems or issues that brought you to counseling: _____

_____

_____

When did these problems or issues develop? _____

_____

_____

What are you hoping to achieve through counseling? _____

_____

_____

Client Problem Assessment

Presenting Problem – Precipitating Stressors: "In recent months, I have been concerned about…"
Please check all that apply, past or present

☐ Marriage ☐ Spouse/Partner ☐ Parent/Child ☐ Family of Origin ☐ Extended Family
☐ Abuse (☐ physical ☐ sexual ☐ psychological ☐ neglect) ☐ Guilt ☐ Shame
☐ Cultural/Ethnic/Race ☐ Health ☐ Job ☐ Financial
Other: _____

Symptoms *Please check all that apply:*

☐ Decreased Concentration ☐ Decreased Motivation ☐ Decreased Energy
☐ Disturbance in Sleep Patterns ☐ Increased Stress ☐ Loss of Control
☐ Decreased Interest in Activities ☐ Numbness or Tingling ☐ Chest Pains / Discomfort
☐ Unexplained Physical Problems ☐ Body Tension ☐ Thoughts of Death/Suicide
Other _____

Major Life Events *Please check all that apply:*

☐ Death of a family member/friend ☐ Divorce ☐ Separation ☐ Imprisonment
☐ Personal injury/illness ☐ Marriage ☐ Job loss ☐ Pregnancy/complications
☐ Career change ☐ Legal problems ☐ Relocation ☐ Holidays ☐ Financial
Other: _____

Suicidal / Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes ☐ No ☐
Is there a history of suicide/homicide in your nuclear and/or extended family? Yes ☐ No ☐
Are you presently suicidal/homicidal? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: _____

_____

Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes ☐ No ☐
Have you ever subjected another person to physical harm? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: _____

_____

Strengths and Weaknesses

Please list what you consider to be your personal strengths and weaknesses.

Strengths	**Weaknesses**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Living Arrangements

Current Address: _____ How Long: _____

With whom do you live? _____

Current relationship with others where you live: _____

_____

_____

Relationship History

Sexual Orientation: _____

Are you married? Yes ☐ No ☐ If not married, are you in a relationship? Yes ☐ No ☐

Name and age of spouse/partner: _____

Date of marriage/cohabitation: _____

Previous marriage/relationship: Yes ☐ No ☐ If yes, name of spouse/partner: _____

If yes, date of divorce/end of partnership: _____

Where children involved in the previous marriage/partnership: Yes ☐ No ☐

What is your perception of the status of your *current* relationship? *(include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.)* _____

_____

_____

Name, ages, and relational history of children from marriages/partnerships.

Name	Age	Comments	Bio, Step, Adopted
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental History

List the members of your family of origin/adoption and your compatibility with each one now.

Family Member	Comments
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What was your birth order: # ____ of ____ children. Who primarily raised you? _____

How would you describe your childhood? ☐ Uneventful ☐ Boring ☐ Traumatic ☐ Painful
☐ Unhappy ☐ Ignored ☐ Neglected ☐ Withdrawn ☐ Other _____

What was life like for you as a child? *(Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.)* _____

_____

_____

_____

Did you experience any traumatic events as a child or adult? *(Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.)*

Date	**Age**	**Event**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Support System

Who do you depend on for support? *(Check all that apply)*

☐ Parents ☐ Siblings ☐ Spouse ☐ Children ☐ Employer ☐ Church ☐ Pastor
☐ Therapist ☐ Extended Family ☐ Neighbor(s) ☐ Close Friend(s) ☐ Co-Worker(s)
☐ Doctor(s) ☐ Support Group(s) ☐ Community Services ☐ Other: _____

Family Involvement

Would it be beneficial for any members of your family to be involved in your treatment? Yes ☐ No ☐
If yes, explain who and why *(complete release of information consent form if needed)*: _____

_____

_____

Legal History *(Please explain all that apply, past and present)*

Charges as a minor: _____

Current Charges: _____

Arrests: _____

Convictions: _____

Parole/Probations: _____

Bankruptcies: _____

Divorce/Separation: _____

Foreclosures: _____

Civil Suits: _____

Financial Situation

Briefly describe your financial situation: _____

_____

_____

Work History

Describe your current job/career: _____

_____

What do you like or dislike about your job and/or career?

Like	**Dislike**
_____	_____
_____	_____
_____	_____
_____	_____

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.

_____

_____

Have you ever been fired from a job? Yes ☐ No ☐ If so, please explain: _____

_____

Educational History

Describe what school was like for you: _____

_____

Highest level of education: _____ What kind of grades did you make? _____

Military History *(Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)*

_____

_____

Religious and Cultural Factors

Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background: _____

_____

_____

Do you have a religious/spiritual background? Yes ☐ No ☐ Preference _____
Do you attend religious/spiritual services? Yes ☐ No ☐ If so, where and how often? _____

_____

Medical History

How would you describe your current health? _____

Are you currently on medications? Yes ☐ No ☐ If yes, please provide information.

Name of Medication	Dosage/Frequency	Prescribing Physician

Has it been more than a year since your last physical exam, including blood work? Yes ☐ No ☐

Have you had or were you involved with an abortion? Yes ☐ No ☐ Miscarriage? Yes ☐ No ☐

List any previous health issues including surgeries, procedures, and medical hospitalizations:

Problem	Date	Treatment

Counseling History *(Please list all previous psychotherapy experiences.)*

Are you or have you ever participated in counseling or psychotherapy treatment? Yes ☐ No ☐

If yes, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

Psychiatric History *(Please list all previous inpatient / outpatient experiences.)*

Have you ever been treated by a psychiatrist/psychologist for a mental health issue? Yes ☐ No ☐

Have you ever been hospitalized for mental health related issues? Yes ☐ No ☐

Have you ever been hospitalized for mental health issues related to substance abuse? Yes ☐ No ☐

If you answered yes to any of the above, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep: _____

_____

Has anyone in your family ever been diagnosed or treated for a mental health disorder, alcohol or drug related problem? Yes ☐ No ☐ If yes, please explain.
Has anyone in your family had problems with alcohol or drugs that was not treated? Yes ☐ No ☐
If yes, please explain.

Family member	**Problem/Disorder**	**Treatment Results (if any)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Use / Abuse History

Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco).

Substance	**Amount**	**Frequency**	**Age of 1st use**	**Age regular use started**	**Age last used**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you experienced an increase in the use of alcohol and/or other substances? Yes ☐ No ☐
Do you see your usage as a problem? Yes ☐ No ☐ If yes, when did it become problematic?

_____

_____

Please describe any previous experience with substances or alcohol _____

_____

_____

Please describe any family history of substance and/or alcohol use _____

_____

_____

Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes ☐ No ☐ If so, please describe _____

_____

_____

Nutrition

Have your eating habits changed recently? Yes ☐ No ☐ If so, please describe _____

_____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes ☐ No ☐
Do you often eat out of depression, boredom, and/or anger? Yes ☐ No ☐ If yes, please describe

_____

Do you use laxatives, water pills (diuretics), or diet medications? Yes ☐ No ☐ If so, how often and for what purpose do you use them? _____

_____

Additional Information

Is there any other information that can be helpful for us to know about you? _____

_____

_____

_____

_____

_____

_____ _____

Client Signature Date

For Office Use Only – Clinician Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Adverse Childhood Experiences Questionnaire
Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **OFTEN** . . .
Swear at you, insult you, put you down, or humiliate you?
OR
Act in a way that made you afraid that you might be physically hurt?
Yes ☐ No ☐ If yes enter 1 _____

2. Did a parent or other adult in the household **OFTEN** . . .
Push, grab, slap, pull your hair, or throw something at you?
OR
EVER hit you so hard that you had bruises, marks, or were injured?
Yes ☐ No ☐ If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **EVER** . . .
Touch or fondle you or have you touch their body in a sexual way?
OR
Try to or actually have oral, anal, or vaginal sex with you?
Yes ☐ No ☐ If yes enter 1 _____

4. Did you **OFTEN** feel that . . .
No one in your family loved you or thought you were important or special?
OR
Your family didn't look out for each other, feel close to each other, or support each other?
Yes ☐ No ☐ If yes enter 1 _____

5. Did you **OFTEN** feel that . . .
You didn't have enough to eat, had to wear dirty clothes, and had no on to protect you?
OR
Your parents were too intoxicated to care for you or take you to a doctor if you needed it?
Yes ☐ No ☐ If yes enter 1 _____

6. Were your parents **EVER** separated or divorced?
Yes ☐ No ☐ If yes enter 1 _____

7. Was your mother, stepmother, grandmother, or other significant female caretaker . . .
OFTEN pushed, grabbed, slapped, had her hair pulled, or had something thrown at her?
OR
SOMETIMES or **OFTEN** kicked, bitten, hit with a fist or hit with something hard?
OR
EVER repeatedly struck over several minutes or threatened with a gun or a knife?
Yes ☐ No ☐ If yes enter 1 _____

8. Did you **EVER** live with anyone who was a problem drinker, an alcoholic, or used drugs?
Yes ☐ No ☐ If yes enter 1 _____

9. Has a household member **EVER** been depressed, mentally ill, or attempted suicide?
Yes ☐ No ☐ If yes enter 1 _____

10. Has a household member **EVER** been arrested, gone to jail, or been in prison?
Yes ☐ No ☐ If yes enter 1 _____

Now add up your "YES" answers: _____ This is your ACE score.

INFORMED CONSENT FOR TREATMENT
& HIPAA GUIDELINES

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your therapist needs to communicate with another about your case, you must give written permission to do so. The only exception to this is, if in accordance with law such communication appears needed to protect you or others from harm or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceases. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide or homicide. The "Health Insurance Portability and Accountability Act (HIPAA)" provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. ****Please read full HIPAA guidelines located under forms on the website prior to your first session.** **

GRIEVANCES

If you feel your privacy rights have been violated in any manner, please communicate this to your therapist to resolve any issues. If the matter is unresolved and you wish to file a complaint please contact the Arizona Department of Health Services at: 1740 West Adams-Room 101, Phoenix, AZ 85007.

INFORMED CONSENT

Christian Counseling Services is a biblically based practice integrating Christian principles with sound psychological techniques. Therapy is an interactive process between client and therapist, and the results of therapy depend heavily on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While we will use our best efforts to assist you, the nature of psychological services is that there can be no assurances of results, and no promises can be made regarding the outcome of any services provides. You should question the rationale of any services, intervention, and discussion if these seem unclear to you. In the case that your therapist is unavailable, or an emergency please call EMPACT at (480) 784 – 1500.

FEES/PAYMENT

Our fees are based on 50-minute sessions. *Longer or shorter sessions are prorated accordingly*. We are an out of network provider. Payment is due at the time of service. FEE: $ _____ per 50-minute session. * *Emergency sessions outside of therapist's standard business hours or workdays, may incur an additional charge of $_____ at therapist discretion.* *****

If you are unable to keep an appointment, please notify the office immediately. **If an appointment is cancelled or missed WITHOUT 24 hours prior notice, you WILL be charged for the missed session. We require a credit card on file for all clients. **By signing you authorize use of this credit card for missed sessions and/or unpaid balances on your account.**

***** CLIENT INITIALS _____ *****

CREDIT CARD# _____ - _____ - _____ - _____ EXP_____ CVV#_____

Zip Code _____ Email address for receipt_____

RESPONSIBILITY

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize my therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. I acknowledge that I have read and understand my HIPPA rights and consent for treatment.

_____ _____

Client OR Parent/Guardian Signature **Date**

After-hours and Emergency Phone Numbers

Maricopa 24-hour Crisis Line (602) 222-9444

EMPACT 24-hour Crisis Line (480) 784-1500

Maricopa Peer Support Line (602) 347-1100

Arizona Department of Health
Division of Behavioral Health Services
150 N. 18th Ave 2nd Floor
Phoenix, AZ 85007
(602) 364 – 4558

Arizona Department of Economic Security
Office of Child Protective Services
Po Box 44240
Phoenix, AZ 85064
(888) 767 – 2445

Regional Behavioral Health Authority
Magellan of Arizona
4129 E. Van Buren St, Suite 250
Phoenix, AZ 85008
(800) 564 – 5465

Office of Human Rights
Division of Behavioral Health Services
150 N. 18th Ave, Suite 200
Phoenix AZ 85007
(800) 867 – 5808

Christian Counseling SERVICES

CONSENT FOR TELEHEALTH CONSULTATION:

Telehealth is any electronic means of communicating with my therapist, including phone calls, text messages, emails, and video-conferencing. Telehealth is utilized with any communication that is not considered administrative in nature (i.e. scheduling, office location, paperwork, etc.).

1. I understand that my provider is able to offer telehealth consultation, including video services, when appropriate and with my expressed consent. I have the right to use and refuse these services for some or all of my therapy.
2. My therapist has explained to me how the video conferencing technology will impact my sessions and therapeutic care. I acknowledge that video sessions will not be the same as an in-person appointment, due to the fact that I will not be in the same room as my provider and that this implies a variety of limitations and differences related to indirect contact.
3. I understand that telehealth has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. In the case of a video session, I understand that I am responsible for ensuring that my location is private and quiet, so that the telehealth session can be completed effectively. I understand that I must provide details about my location (such as: the physical address, online map pin/link, or a visual of the room) and my identity (such as confirming details about myself against my record or giving a predetermined password) at the onset of a telehealth session. This is necessary to protect my confidentiality and ensure that the coverage of my provider's license extends to my location.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that provider or I can discontinue a telehealth appointment if it is felt that the Internet connections are not adequate for the situation or my confidentiality is compromised.
6. I understand that there are some legal and ethical limitations and considerations regarding telehealth sessions, including: risk assessment, technology competence, effectiveness of the therapeutic model, long-term sustainability, national emergencies, and more. My therapist has the right to refuse to offer telehealth sessions, in accordance with state and board statutes.
7. I understand that there are innate risks to my privacy and confidentiality associated with using any telehealth service, specifically video conferencing technology. In offering telehealth for my convenience, I acknowledge that my provider cannot be responsible for these risks, though they will do their best to maintain my confidentiality whenever possible
8. I understand that I have the right to request the use a safe word, if I feel that my situation warrants extra protection or if I am not confident that my confidentiality will be maintained during a telehealth session (for example: conducting a session with children or a spouse in another room who could interrupt). The safe word selected should be easy to insert into conversation, if the safety or privacy of either location is compromised. If a safe word is needed, it should be established with my provider before the start of a session.
9. If a scheduled telehealth session cannot be completed as planned (due to complications such as, but not limited to: technical difficulties, confidentiality issues, or client discomfort), I

understand that I MAY be responsible for a fee, in accordance with my provider's late cancellation policy. These instances are few and far between and should this problem arise, I will need to discuss the implications with my provider to determine whether a full/partial fee or waiver applies.

10. I acknowledge that telehealth is NOT an emergency/crisis service and in the event of an emergency, I will use a phone to call 911.
11. I acknowledge that the developers/administrators of the telehealth platform used for my sessions are not responsible for the delivery of any healthcare, medical advice, or care.
12. I do not assume that my provider has access to any or all of the technical information related the use of a telehealth service. Specifically, I will not rely on my therapist to provide technical support for using a video platform. If a technical issue arises, a reasonable amount of time can be spent trying to resolve the problem, so that the session can be completed. However, if the issues are not resolvable after 10 minutes, the session may need to be rescheduled or moved to a different telehealth platform. If we get unexpectedly disconnected and cannot rejoin the conference room, I can contact my provider via text, phone call, or email to discuss an alternate platform and/or rescheduling.
13. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. My session will also not be recorded by my therapist without my consent.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this service and respective policies. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me, in a language in which I understand.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me.

· That I fully understand its contents including the risks and benefits of the procedure(s).

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature _____

Printed Name _____ Date _____