A&M CHRISTIAN COUNSELING Center

Client # _____

# Clinical Intake Form

**This information will remain confidential.**

Date: _____

Client name: _____ DOB _____ Age:_____

Gender: Male___ Female___ Ethnicity/Race: _____

Spouse's Name: _____

Address _____ City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Employed at: _____

Occupation: _____

## Referral Information

How did you hear about us?

____ Referred by therapist _____

____ Referred by a friend

____ Referred by a minister/pastor _____

____ Web Site

Other _____

## Relationship status:

Current Relationship status: ____Single ____Married ____Divorced ____Widowed ____Separated _____Living together

How long have you been together: _____

If married, how long have you been married?_____ How many times have you been married? _____

**Current Household Family**: Do you have children? Yes No If yes provide information below:

| Name | Age | Lives at | (Circle one) |
|---|---|---|---|
| | | | biological/adopted/step-child |
| | | | biological/adopted/step-child |
| | | | biological/adopted/step-child |
| | | | biological/adopted/step-child |
| | | | biological/adopted/step-child |
| | | | biological/adopted/step-child |

## Family-of-Origin

Mothers Age:_____ If deceased, how old were you when she died?_____

Father's Age:_____ If deceased, how old were you when he died?_____

Number of Brothers:____ Their ages:_____

Number of sisters: ____ Their ages:_____

Briefly describe your relationship with your father:

_____

Briefly describe your relationship with your mother:

_____

## Educational Background:

GED HS Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate Degree Other

If degree applies please specify major: _____

## Religious / Spiritual Background:

Were you affiliated with any church / religion growing up? Yes___ No____ What Church or Religion?_____
Are you currently affiliated or attending a church/religion now? Yes___ No____ What Church or Religion?_____

Describe your religious upbringing? _____
_____

## Medical History:

Do you have any significant health/medical issues? Yes ___ No ___ If yes what is/are the health issue(s) and are you limited in any way?

_____

_____

_____

Date of last medical exam: _____ Medical doctor & phone #: _____

Have you ever had a trauma to head, unconsciousness, or seizures? Yes___ No____

If yes, explain _____

## Mental Health History

Are you currently in therapy or counseling with anyone? Yes____ No____

With Whom _____ Where _____
How long _____ Reason _____

Describe the experience _____

Do you have previous therapy experience? Yes ___ No ___

| When | Where | Presenting issue | Diagnosis |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever been hospitalized for any mental health reasons? Yes____ No_____

| When | Where | Presenting issue | Diagnosis |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you currently taking any psychotropic medications? Yes____ No____ (Specify current & past meds)

| Medication | Condition | Dosage | # times/day | Date began medication | Physician |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Alcohol/drug usage**:
Do you currently use alcohol or drugs? Yes____ No____

Describe the use of drugs and alcohol (type, amount, frequency): _____

When did you start using drugs or alcohol? _____

What has your past use of alcohol been like? _____

**Suicide risk**: Have you ever attempted suicide? Yes____ No____
If yes, when? _____ How many times? _____

Have you recently had thoughts of suicide? Yes____ No____

How or what did you plan to do? _____

What were the circumstances at the time? _____

Has anyone close to you ever attempted or committed suicide? Yes____ No____

If yes, who, how, and when? _____

**Abuse history**: Have you ever been physically, emotionally, or sexually abused? Yes____ No____
If yes, briefly explain (who, what and when): _____

_____

**Support Systems**:
Do you have people that you can turn to for support? Yes____ No____

If yes, who? _____

**Presenting Issues**:
What is your main concern that brings you in today? _____

_____

What changes would you like to see as a result of counseling?

_____

**Areas of Concern or Stress: (use an x for current concerns; circle past concerns)**

**Life Adjustment Problems:**

__ Divorce or Separation

__ Newly married or remarried

__ Stepfamily with children

__ Moving to new location

__ Parenting a newborn

__ Being a single parent

**Family Concerns:**

__ Custody or visitation problems

__ Parent / Child conflicts

__ Major difficulties with child or teen

__ One or more family members not getting along

__ Adolescence issues

## Personal or Relational Concerns:

__ Grief/mourning following loss

__ Depressed

__ Anger or difficulty controlling temper

__ Stressed

__ Loneliness

__ Anxiety (Specific: _____)

__ Guilt

__ Physical problems

__ Drug Use

__ Financial difficulties

__ Employment difficulties/stress

__ Sleeping problems

__ Alcohol Use

__ History of traumatic experiences

__ Sexual abuse __Rape

__ Incest __ Assault

__Use of internet

__ Pornography

__ Sexual Concerns

__ Arguing or handling conflict

__ Infidelity

__ Emotional abuse by partner

__ Physical abuse by partner

__ Lack of emotional support

__ Problems with relatives

__ Communication Issues

__ Fear (Specify:_____)

__ Nightmares:

__ Weight change

__ Panic Attacks

__ Lack of concentration

__ Eating concerns/body image

__ Spiritual or Religious Issues Explain: _____

__ Other concerns (Please specify) _____

## Emergency Contact Information

Name _____ Relationship _____

Phone #(s) _____

## COUNSELING SERVICES

When you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications with a psychotherapist in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. A *Notice of Privacy Practices* will be provided to you.

## AUTHORIZATION FOR CLINICAL SERVICES

I request treatment from A & M Christian Counseling Center for outpatient mental health services and hereby authorize the clinical staff to administer such treatment as is deemed necessary. I also certify that no guarantee or assurance has been made as to the results or outcomes that may be obtained. Treatment includes the risk of emotional discomfort related to issues discussed during the counseling process. I understand that I am free to discontinue therapy at any time. I am aware that the center is not an emergency or 24 hour service. After hours, clients are requested to call their primary care physician or 911 for an emergency.

## FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further agree that a photocopy of this agreement shall be as valid as the original.

| Yearly Family Income | 50 Minute Session |
|---|---|
| Up to $30,000 | $45.00 |
| $30,000-$50,000 | $65.00 |
| $50,000 and up | $85.00 |

The fee for services rendered by a practicum student will be $35.00 per session. Please see the "Supervisory Status Disclosure" attached.

You have the right to be informed of the cost of services rendered to you. The charge, $_____ , which corresponds with my family income is due in full at the time services are rendered unless previous arrangements have been made (initial _____). Payment options are available.

We require that the AMCCC receive notification, at least 12 hours in advance, should you wish to cancel or reschedule an appointment. Failure to do so may result in a $45.00 cancellation charge (initial _____)

Should the need arise for the therapist to appear in court to testify, the hourly rate of $150.00 will apply. These rates will be charged in four hour increments which include time spent on preparation, travel, waiting and testimony. These charges are not allowable charges for insurance and will be the sole responsibility of the client. As it is often difficult to accurately determine the time needed to appear in court it is necessary for the therapist to clear their entire day making it necessary to charge in this way.

## AUTHORIZATION TO LEAVE INFORMATION BY ALTERNATE MEANS

I authorize the A&M Christian Counseling Center to contact me through the following ways for a reminder about my scheduled appointment with a therapist.

**Check one**

_____ text messages - cell # _____

_____ phone messages – phone # _____

_____ email _____

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my record and that the communication instructions listed above will remain in effect until revoked by me in *writing*. It is my responsibility to make the changes in writing should I choose to change any information or authorization.

## SIGNATURE

I certify that the information that I have provided on this form is true and accurate. I have read and understand the above rights, authorizations and responsibilities and have signed below to indicate my agreement with these terms.

I have received a copy of Counseling *Notice of Privacy Practices* and have signed below to indicate my agreement with its terms.

**Client Signature_____**

**Client Name (please print) _____**

**Date: _____**