Confidential Client Intake Form

Date: ________________________

Name: __________________________________ Gender: Male Female Age: ___________

Address: ___________________________City/State: __________________ Zip : ___________

Primary Phone Number: ______________________ May we leave a message here: Yes No

Second Phone Numbers: ______________________ May we leave a message here: Yes No

Birth date: ______ / ______ / _________ Email Address: ________________________________

With Whom Do You Currently Live: (Please check all that apply)

Alone Parent(s) Spouse Children Boyfriend Girlfriend Other: ________________

Marriage & Family Information: (Please complete if you are currently engaged)

Name of Spouse: ______________________________________ Your Spouse's Age: _________

Address: (same as above) ____

Phone Number: _________________________ Email Address: __________________________

Occupation / Employer:________________________________ Avg. Hours/Week: ___________

Highest degree(s) earned: _____________________________ School:______________________

Is spouse willing to come for counseling? Yes No Uncertain

Have you ever been separated? Yes No When/How Long? _________________

Date of Marriage: _______________ Your ages when married: Husband _______ Wife ________

How long did you know your spouse before marriage? _______________

Give brief information about any previous marriages:

Ex-Spouse's Name	Date	Length of Marriage	Reason for Divorce	# Kids

* Other relevant information can be written on the back of this page.

Child's Name	Living	Age	Gender	At Home	Married	Special Condition(s)	*CM/PM/A
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		

* Check this column if child is by current marriage (CM) previous marriage (PM), or adoption (A).

Spiritual / Religious Information

DO YOU CONSIDER YOURSELF A RELIGIOUS PERSON? Yes No

Church Name (if applicable): ____________________________________Number of Years at Church: ______

Pastor's Name: ____

Can we speak to your pastor about our counseling sessions? Yes No

Denominational Preference: ______________________________ Church Attendance: _____ Times per month

If applicable, what is the religious background of your spouse: _______________________________________

Spouse's church attendance: ________ Times per month

Do you pray to God? Yes No How often? ____

What do you pray about? ____

Have you received Jesus Christ as your savior? Yes No Uncertain Don't know what you mean

If yes, how do you know that Jesus Christ is your Savior?

____

Please note any recent changes in your spiritual life: ____

Health Information

Have you had counseling before? Yes No Have you seen a psychiatrist before? Yes No Currently

Age	Duration	Counselor/ Center	Issue(s) / Topics(s) / Diagnosis	* Your Evaluation of Counseling

* Use back of this page if necessary or if you need more space

Approximately how many hours of sleep do you get each night? ______________________________________

When do you normally: go to bed? ______ fall asleep? ______wake up? ______get out of bed? ______

Describe any recent changes in sleep habits: ____

State of current health: Very good Good Average Declining Other: ___________________________

Current illness, injury, or disability: ____

Are you presently taking any medication? Yes No

Medication	Dosage	Frequency	Prescribed for…	Date began taking…

Number of non-working hours per week spent watching television ____ on computer ____ hobbies ____

Please check any of the following physiological symptoms that apply to you.

Headaches …… Past Present Difficulty Breathing.. Past Present Rapid Heart Rate ... Past Present

Visual Trouble Past Present Tension ………….. Past Present Dizziness ……… Past Present

Weakness …… Past Present Fatigue ………….... Past Present Pain …………….. Past Present

Sleep Trouble .. Past Present Change in Appetite.. Past Present Other (on back) …. Past Present

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

Check any of the following struggles you and/or your family are experiencing at this time:

Abuse, Physical … You Family
Abuse, Sexual…... You Family
Abuse, Verbal ….. You Family
Abuse in Past …... You Family
Addiction ……..... You Family
Anger …………. You Family
Anxiety ………... You Family
Apathy …….…... You Family
Bad Memories…... You Family
Bitterness………. You Family
Caring for Parents You Family
Chronic Pain…..... You Family
Codependency...... You Family
Communication:
-affection……… You Family
-day to day…….. You Family
-emotions……… You Family
-planning……… You Family
-problem solving You Family
Compulsions…... You Family
Depression……... You Family
Debt …………... You Family
Discontentment… You Family
Divorce Recovery.. You Family
Doubting Salvation You Family
Eating Disorder ... You Family
Empty Nest…….. You Family

Envy…………..... You Family
Fear ………..…..... You Family
Financial Mngt…. You Family
Greed…………..... You Family
Grief…………….... You Family
Guilt…………….... You Family
Homosexuality….. You Family
Humility……….. You Family
Identity………..... You Family
Impatience……..... You Family
Infertility……….... You Family
Insecurity……….... You Family
In-Law Conflict... You Family
Jealousy……….... You Family
Judgmental…….... You Family
Leadership……..... You Family
Lifestyle Change.. You Family
Loneliness……..... You Family
Lying …………... You Family
Manipulation …... You Family
Marital Intimacy.. You Family
Moodiness…….... You Family
On-Line Sins…..... You Family
Panic Attacks…... You Family
Parenting ……..... You Family
Parenting Adult Child You Family
Peer Pressure…..... You Family

People Pleasing… You Family
Perfectionism…... You Family
Pornography……... You Family
Pre-Marital Sex.... You Family
Pride…................ You Family
Priorities…........... You Family
Procrastination… You Family
Purpose, Lack of… You Family
Rebellion……… You Family
Rejection………. You Family
Relationships…... You Family
Respecting Authorities You Family
Respecting Parents You Family
Respecting Spouse You Family
Same Sex Attraction You Family
Self-Control……. You Family
Self-Injury……... You Family
Selfish …............. You Family
Shame…………. You Family
Social Anxiety…. You Family
Spiritual Growth… You Family
Submission……... You Family
Suicidal Thinking.. You Family
Time Management You Family
Work Unfulfilling You Family

Other Information

If you were reared by someone other than your own parents, briefly explain: ______________________________

____

Number of older brothers: ____ Older Sisters: ____ Younger brothers: ____ Younger Sisters: ____

Step/half: ____ Step/half: ____ Step/half: ____ Step/half: ____

The town I grew up in was urban suburban small town rural changed frequently.

My family's financial situation was poor lower middle middle class upper middle class wealthy.

Did you have any significant traumatic events as a child? Yes (please describe on back) No

Which of the following words best describe your home of origin (check all that apply):

Traditional	Authoritarian	Unpredictable	Divorced	Lonely
Substance Abuse	Physical Abuse	Verbal Abuse	Perfectionist	Critical
Sexual Abuse	Affectionate	Affirming	Safe	Permissive

1. Please describe the current problem, as you understand it.

____

____

____

2. What have you done about it (most effective and least effective)?

____

____

____

3. Other than counseling, what help are you seeking?

____

____

____

4. Who referred you to this ministry for help?

____

5. Please describe any family history (the family that you grew up in), which might be pertinent to the concerns that you bring to counseling (your relationship with your parents, their relationship with each other, significant losses or events):

____

____

____

6. What are your expectations in coming here?

____

7. What, if any, are your concerns about coming to counseling?

8. What do you believe you will have to change to see the progress you desire?

9. Is there any other information we should know?

Thank you for taking the time to complete these forms. The information you have provided will enable us to better serve you.

Impact Biblical Counseling Policy Review

Instructions for Policy Review: After carefully reading each policy please place your initials in the space provided to indicate your understanding and agreement with each policy. If you have questions please direct them to your counselor before your next meeting. If for any reason you are unable to sign these forms, counseling services will be denied to you.

Financial Policy
Impact Biblical Counseling is solely supported and able to operate because of its fee structure. The per hour fee for counseling is $100 per hour. We can take cash, checks, and credit card payments at the time of service. At this time checks for counseling services should be made out to Impact Biblical Counseling.

*** Initial here if you understand and agree with this Financial Policy: __________

Appointment Cancellation Policy
We require a 24 hour notice if you wish to cancel or are unable to keep an appointment. If you fail to give us a 24 hour notice you will be expected to pay a missed appointment fee.

$45.00 for the first appointment missed or cancelled with insufficient notice.
$60.00 for the second appointment missed or cancelled with insufficient notice.
$75.00 for all subsequent appointments missed or cancelled with insufficient notice.

*** Initial here if you understand and agree with this Cancellation Policy: __________

Philosophy of Care
We are committed to providing a balance in our approach to counseling. It is our belief that all inner conflicts are both psychological and spiritual, because your mind, emotions, and will are always involved and because God is always present and His Word is always applicable. It is our goal to provide the highest quality of care that meets your specific needs and honors Christ.

We believe that our past helps shape our present beliefs and behaviors and also influences future beliefs and behaviors. We will address some of the strategies that obstruct us, the foundational issues of our identity, and outline practical steps on how to live by faith, renew your mind, manage your emotions, and resolve emotional trauma of the past or present through faith and forgiveness.

When necessary we will work with your physician to ensure you receive the appropriate medical care in conjunction with the counseling services you receive.

*** Initial here if you understand and agree with this Philosophy of Care: __________

Confidentiality Clause
The privacy and confidentiality of our conversations and records are a privilege of yours and are protected by our ethical principles in all but a few circumstances. Those exceptions are limited to the following: known or suspected child or elderly abuse; the intent to take criminal actions against another person; active suicidal ideations; and, counseling that is mandated by a legal authority, then it is assumed by your initials that you agree that your counselor may give/receive updates and opinions and share records for the purpose of professional continuity.

Your counselor reserves the right to consult with other counselors at Impact Biblical for the purpose of providing the highest level of care. As a para-church ministry, your counselor reserves the right to involve the church where you hold membership for the purpose of cooperative pastoral care.

*** Initial here if you understand and agree with this Confidentiality Clause: __________

Waiver of Liability
In seeking counseling from Impact Biblical Counseling, we ask that you must acknowledge your understanding of the following conditions and further release Impact Biblical Counseling, its agents, affiliates, counselors, employees, Board of Directors, and all ministry team leadership, from any legal liability, claim, or litigation arising from your participation in this voluntary program:

1. Counseling will be provided by ordained ministers or a counselor from a pastoral and biblical perspective. The counseling staff at this time is not a licensed counselor in the state of Oregon.

2. All counseling is provided in accordance with the biblical principles adhered by Impact Biblical Counseling and are not necessarily provided in adherence to any local or national psychological or psychiatric association;

3. No representation has been made, either expressly or implied, that the biblical counseling, as conducted by the above mentioned counselors, is accepted as customary psychological and/or psychiatric therapy within the definitional terms utilized by those professions;

4. It is understood by the participant counselee(s) that all complaints and grievances will be heard by the Executive Directors and/ or your local church leadership. If the goal of reconciliation cannot be achieved between the aforementioned parties, then the participant counselee(s) will involve Peacemaker Ministries, Inc., at their expense, for the purpose of mediation or arbitration.

*** Initial here if you understand and agree with this Waiver of Liability: __________

Consent to Counsel
Having read and understood Impact Biblical Counseling's Financial Policy, Appointment Cancellations Policy, Confidentiality Clause, Waiver of Liability and Philosophy of Care, I, ________________________________ ___________________________ (print name) grant permission for Impact Biblical Counseling to render counseling services to me and the names listed below (please include the names of those who may be involved in the counseling process): ____

I also understand that Impact Biblical Counseling may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, or for other issues agreed upon by the Board of Directors.

Please sign to indicate the following:

1. You have read the policies in this document;
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into counseling of your own will.

Client Signature: _________________________________ Date: _________________

Client Signature: _________________________________ Date: _________________ (If more than one.)

Counselor Signature: _________________________________ Date: ______________