



ADULT CLIENT INTAKE FORM

*Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist.
Information you provide here remains confidential.*

Please describe the main issue, reason, or event that brought you here today:

CONTACT INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ May we leave a message? _____

Home Phone: _____ May we leave a message? _____

Relationship status (Check all that apply):

Married Separated/Divorced Live with partner Single Widowed

Employment status and title: _____

Faith/religious orientation: _____

EMERGENCY INFORMATION

In case of an emergency please contact: _____

Relationship: _____

Phone: _____

TREATMENT HISTORY

Are you currently receiving any other mental health services?

yes no

Have you had previous psychotherapy?

no yes, with (previous therapist's name) _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

yes no

If yes, please list: _____

Prescribed by: _____

HEALTH INFORMATION

Does you currently have a primary physician? yes no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? yes no

If yes, please list: _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Are you currently on medication to manage a physical health concern? If yes, please list:

EXERCISE

How would you describe your physical activity?

little to no exercise a few times a month a few times a week nearly every day

APPETITE

Are you having any difficulty with appetite or eating habits? no yes

If yes, check where applicable and explain: Eating less Eating more Bingeing Restricting

Have you experienced significant weight change in the last 2 months? no yes

SLEEP

Are you having any problems with your sleep habits? yes no

If yes, check where applicable and describe:

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams other

SUBSTANCE HISTORY AND USE

Please list any legal/illegal substances used by you in the past and/or present including alcohol, and tobacco (current/past use, how much/often, last time used):

SUICIDE ASSESSMENT

Have you had thoughts of harming yourself recently? yes no

If yes, how often: frequently sometimes rarely never

Have you had them in the past? yes no

If yes, how often: frequently sometimes rarely never

Have you attempted suicide? yes no If yes, when? _____

Have you ever experienced any of the following?

Symptom	Circle one	If yes, please explain (include frequency)
Extreme depressed mood	Yes / No	
Dramatic mood swings	Yes / No	
Rapid speech	Yes / No	
Extreme anxiety	Yes / No	
Panic attacks	Yes / No	
Phobias	Yes / No	
Sleep disturbances	Yes / No	
Hallucinations	Yes / No	
Unexplained losses of time	Yes / No	
Unexplained memory lapses	Yes / No	
Alcohol/substance abuse	Yes / No	
Frequent body complaints	Yes / No	
Eating disorder	Yes / No	
Body image problems	Yes / No	
Repetitive thoughts (e.g. obsessions)	Yes / No	
Repetitive behaviors (e.g. frequent checking, hand washing)	Yes / No	
Homicidal thoughts	Yes / No	
Suicidal attempts	Yes/No	If yes, when?
Other		

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g. sibling, parent, uncle, etc.)

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	
Adoption	Yes / No	
Abuse	Yes / No	
Other (use box to explain)		

TRAUMA ASSESSMENT

Have you personally experienced or witnessed any of the following? If yes, were you the victim or the witness?

Experience	Please circle	Victim	Witness	OTHER INFORMATION
Physical abuse	Yes / No			
Sexual abuse	Yes / No			
Emotional/mental abuse	Yes / No			
Neglect	Yes / No			
Abandonment	Yes / No			
Community violence	Yes / No			
Bullying	Yes / No			
Natural Disaster	Yes / No			
Other	Yes / No			

CHANGES/STRESSORS/LOSSES

In the last year, have you experienced any significant life changes, stressors or losses? (Examples include moving, new job, changes in the family, divorce, loss of a family member or friend, serious illness, etc.).

If yes, please list them here:

SOCIAL/RELATIONSHIP HISTORY

Are you currently in a romantic relationship? no yes

If yes, how long have you been in this relationship? _____

Are you satisfied with your current relationship? no yes Unsure

Are there past romantic relationships you would like to discuss in therapy?

OCCUPATIONAL INFORMATION

Are you currently employed? no yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any:

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? no yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? no yes

Would you like your therapist to incorporate faith/spirituality into the sessions? no yes

Are you looking for court related services? If yes, please explain.

What do you consider to be your strengths?

What do you consider to be your weaknesses/limitations?

What do you like most about yourself?

What are effective coping strategies that you have learned?

What are your goals for therapy?

VALLEY CHRISTIAN COUNSELING

Informed Consent

Overview

Welcome to Valley Christian Counseling. The following information is to assist you in establishing your expectations for psychotherapy and functions as an agreement between you and your therapist. Please read the following carefully and complete all sections before the first session. Please feel free to call with any questions or concerns throughout the course of treatment.

Sessions

Therapy appointments are approximately 45-55 minutes in duration, however longer sessions are also available upon advanced request. The number of sessions is determined by both the therapist and the client depending on the client's individual needs.

Cancellation Policy

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled without 48 hours' notice, the clinician reserves the right to charge you a missed/cancelled appointment fee equal to your agreed upon session rate.

Confirmation Calls

To better serve our clients, our staff strives to provide confirmation calls to remind you of your appointment approximately 48 hours in advance. However, please make efforts to set self-reminders in the event we are not able to place a call.

Emergency Options and Additional Resources

If you are unable to reach our office during normal business hours and are experiencing a crisis or medical emergency please call 911 or head to your nearest emergency room.

Records

Your professional records may include information regarding your reason for seeking therapy, a description of the impact your problems may be having on your life, your treatment goals and your progress toward said goals, your medical and social history, your billing records, and any reports received from other clinicians. You have the right to review your records at any time however, it is recommended that the records be reviewed in the presence of your therapist before viewing them individually. A fee may be applied to the request of your records. Your records are stored in a locked filing cabinet behind two locked doors, and will be stored for 7 years (per requirements of the Alabama Board of Social Work) before being properly destroyed.

Offsite Consultation

Consultations are sometimes requested by other professionals involved in your care. In the event that you or another professional request a consultation, your clinician reserves the right to bill at the hourly rate for consultation services. It is important to note that billable time may also include travel and prep time.

Minors and Parents

Children under the age of 14 cannot consent to therapy on their own, however in the State of Alabama a minor child over the age of 14 may seek therapeutic services without the consent or knowledge of their parents/guardians. Children over the age of 14 have the right to privacy and the parents are not privy to confidential information, unless a release has been obtained. The Clinician will strongly urge the teenager to sign said release as treatment is often inhibited when guardians are not involved in the process. Clients under the age of 14 cannot consent for themselves and therefore will need the permission of a guardian to seek therapeutic services. If a child is in danger or is a danger to someone else, the therapist will notify the parents of this concern as well as the appropriate authorities if necessary. Before, giving sensitive information to parents, the clinician will discuss the matter with the child, if possible, and do their best to mitigation any objections and explain the benefits of guardian support.

Contacting your Clinician

If you need to contact your clinician, please call Valley Christian Counseling Center and leave a message with the receptionist or on the appropriate extension. Your therapist will periodically check messages, and return your call as soon as possible.

Release of Information

Valley Christian Counseling is not a HIPAA covered entity; however, your therapist is subject to all ethical and legal standards that protect your confidentiality. We will only disclose your personal information given legal obligations due to a duty to report and/or given your written authorization.

Limits on Confidentiality

1. Occasional consultations with other mental health professionals about a case are helpful or even necessary in order to provide quality care. We make every effort to ensure your confidentiality during this process.
2. If you or a minor in your care are a harm to yourself or others, I have a duty to report in order to prioritize your safety.
3. The following are some examples of situations in which I may be required or legally permitted to disclose information without your consent or authorization:
 - a. Requests made from court order
 - b. In the event I become the defendant in a case filed against me I have the right to release privileged information that may be relevant to my defense.
4. I am considered a mandatory reporter, meaning if I suspect that any vulnerable population is being abused and/or neglected that I must report to the appropriate authorities.

Print Client Name

Date

Client Signature

Date

Clinician's Signature

Date

*The above signature certifies that I understand that I am consenting to counseling services, and that I understand the limits of confidentiality within those services.

VALLEY CHRISTIAN COUNSELING

Client Rights

As a client, you can expect:

- Humane care and treatment, with respect and consideration
- Privacy and confidentiality when seeking or receiving services except in the case of life-threatening situations or conditions
- Confidentiality of your health records
- Accurate information concerning diagnostic impressions, treatment, and risks
- Active participation in decisions regarding your own treatment
- Accessible information regarding the scope and availability of services
- Information about any legal reporting requirements regarding any aspect of screening or treatment
- A copy of your records upon request and written authorization
- Ability to file a complaint with the director of VCC regarding any concerns related to the privacy, confidentiality or security of your medical record
- Competent treatment in a respectful environment that acknowledges your dignity and worth
- To gain knowledge regarding strategies and therapy techniques used to aid in your treatment
- Participation in establishing and reestablishing goals throughout therapy
- Option to participate in or refrain from services (except when mandated)
- Ability to request referrals for alternative services

Print Client Name

Date

Client Signature

Date

Clinician's Signature

Date

VALLEY CHRISTIAN COUNSELING

Financial Agreement

Thank you for choosing Valley Christian Counseling to be your mental health provider. We are committed to providing the best care possible. It is important that you understand that payment for services is considered part of your treatment; therefore, the following information explains our financial policies. We ask that you sign this form as an indication that you have read and agree with the information presented.

Reimbursement/Insurance Coverage

Your clinician does not accept insurance. However, you may submit to your insurance for reimbursement as your clinician would be considered an Out-of-Network Provider. Your clinician does not determine how your insurance will reimburse counseling services, that is between you and your insurance company. Your clinician's fees are subject to change and you will have advance notice of those changes as they arise.

Methods of Payment

We ask that you pay in full upon the time of services, unless previously agreed upon by you and your therapist. We accept most forms of payment including cash, check, or credit card.

Unpaid Balance

If you accrue an unpaid balance, we ask that you make arrangements to pay balance within 30 days. In the event that we cannot reach you to collect payment, Valley Christian Counseling may pursue reimbursement by submitting a claim to small claims court, or hiring a collections agency. Payment plans may be offered when requested with approval from director of VCC. Confidential information may be shared in claims court or to collections agency on as needed basis.

Late Cancellation/No Show Fees

If cancellations have not been made within 48 hours of the appointment or client did not show up for the session, the client is subject to a no-show fee. Exceptions are made in cases of emergencies. Late cancellation/no show fee is \$55.00; however, the clinician reserves the right to charge the entire session fee of \$110.00 if the client is a repeat offender. Grace is often offered, especially in unforeseen circumstances. Your practitioner asks for communication and in response fees may be waived at your practitioners' discretion.

Court Related Fees

Clients who require court related services can expect a rate of \$200 per hour. Court related work can include, but not limited to, consultations, phone calls, travel time, depositions, and time spent at court. There is a minimum retainer fee of \$1000 to appear/testify in court. Payment must be received 48 hours prior to the court appearance. Subpoenas must be received within 48-hour notice or client may be subject to an additional charge of \$200. In the event that the court date is rescheduled with less than 72 business hours, the clinician reserves the right to charge an additional fee of \$300 in addition to any previous accrued fees. It is important to note that any given testimony may not result in your favor. In the event that you lose your case, you will still be responsible for court related fees.

Statement of Understanding

I certify that I understand the above statement and I agree to its terms. By signing below, I am stating that I have read and agree with the financial fees set by my practitioner. I understand that Valley Christian Counseling and/or my practitioner reserve the right to adjust or lower that fee on as needed basis.

Print Client Name

Date

Client Signature

Date

Clinician's Signature

Date