VALLEY CHRISTIAN COUNSELING

Welcome to Valley Christian Counseling and thank you for trusting us with your care. To better serve you, please fill out the following information before your first session. The information you provide will be kept confidential. If there are questions you would rather leave blank or discuss with your care provider, please feel free to do so.

PASTORAL COUNSELING CLIENT INTAKE FORM

Name: _____

Date: _____

Occupation: _____

Address: _____

Preferred phone number: _____

Is it okay to leave a message/receive a text reminder? _____

Email: _____

Date of birth: _____

Ethnicity: _____

Faith/Religious Orientation: _____

Marital Status: _____

Children (and ages) if any: _____

Emergency Contact: _____

Phone Number for Emergency Contact: _____

5151 Research Drive NW Suite 1B Huntsville, AL 35805 ~ Phone: (256) 722-8091 ~ Fax: (256) 270-7019

How did you hear about my services? _____

What influenced your decision to seek pastoral counseling? _____

_____

Have you attended counseling in the past? If so, please describe the duration and date of

counseling: _____

Describe the main issue/reason/event through brought you to counseling:_____

_____

_____

_____

How long has this issue been present in your life? _____

Where are your concerns causing the most problems for you (circle), home, work, relationship, or God?

Have any concerns about you been noticed by others? _____

SPIRITUAL HEALTH

On a scale of 1 to 10, how satisfied are you with your spiritual life? _____

Describe your current relationship with God: _____

_____

Do you have current church support and involvement? _____ If so, describe your

current church support/involvement: _____

_____

Is there additional spiritual information you feel would be beneficial to know? _____

_____

PHYSICAL HEALTH

Do you currently have a primary care physician? _____

What was the date of your last physical? _____

Are you currently on any medication? _____

How would you describe your physical activity (circle answer), daily, weekly, or rarely?

How would you describe your sleep habits (circle answer), 8 hours per night, 6 to 7 is all I need, less than 5 hours.

Do you have difficulty falling asleep? _____

Do you have difficulty staying asleep? _____

Are you having any difficulty with your eating habits, if so please describe. _____

_____

Have you recently experienced thoughts of harming yourself or others? _____

Have you ever attempted suicide? _____

SOCIAL HEALTH

Do you feel you have adequate social support (friends/family)? _____

Do you have and maintain close relationships? _____

How often do you participate in social activities (circle), at least 1/week, monthly, on occasion, or rarely?

Do you participate in any hobbies?_____

Please indicate which of the following areas are current concerns for you. Check all that apply.

- ☐ Extreme depressed mood
- ☐ Feeling angry
- ☐ "Numb" or cut off from emotions
- ☐ Difficulty making decisions
- ☐ Sexual attracted concerns
- ☐ Loss of memory
- ☐ Change in appetite
- ☐ Issues with food and/or weight
- ☐ Parenting
- ☐ Crying spells
- ☐ Loss of interest in activities
- ☐ Loss of motivation
- ☐ Excessive fear
- ☐ Inability to control thoughts
- ☐ Feeling lonely
- ☐ Concerns about finances
- ☐ Relationship conflict
- ☐ Difficulty making friends
- ☐ Feeling manipulated or controlled
- ☐ Changes in sexual relationship
- ☐ Insomnia or Hypersomnia
- ☐ Lack of self-confidence
- ☐ Substance Abuse
- ☐ Feeling distant from God
- ☐ Inability to concentrate
- ☐ Nightmares
- ☐ Obsessive/Compulsive concerns
- ☐ Anxiety
- ☐ Dramatic mood swings
- ☐ Difficulty sustaining relationships
- ☐ Home/family life concerns
- ☐ Significant relationship loss
- ☐ Divorce
- ☐ Infidelity
- ☐ Broken trust
- ☐ Job stress
- ☐ Marital conflict
- ☐ Empty Nest
- ☐ Concerns about physical health
- ☐ Life Transitions
- ☐ Boundaries

Is there a known family history of the issues listed above? If so, please describe: _____

_____

What would you like to accomplish or gain from your pastoral counseling sessions? _____

_____

What actions have you taken to deal with the issues listed above (ie: Small group, support

group, counseling)? _____

Describe any strengths that you have that would help the success of pastoral counseling: _____

_____

Describe any weaknesses that you feel could hinder the success of pastoral counseling: _____

What additional information would you like to share or feel would be beneficial to the pastoral counseling session?

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Informed Consent

Sessions

Therapy appointments are approximately 45-55 minutes in duration. Longer sessions are available upon advanced request. The number of sessions is determined by both the provider 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 canceled without 24 hours' notice, the clinician reserves the right to charge you a missed/canceled appointment fee equal to your agreed-upon session rate.

Emergency Options and Additional Resources

If you cannot 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 pastoral care, a description of the impact your problems may be having on your life, your session goals, and your progress toward said goals, your medical and social history, your billing records, and any reports received from other providers. 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 care provider before viewing them individually. A fee may be applied to the request for your records.

Contacting your Care Provider

If you need to contact your care provider, please call Valley Christian Counseling Center, and leave a message with the receptionist or on the appropriate extension. Your provider 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 care provider is subject to all ethical 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 to provide quality care. We make every effort to ensure your confidentiality during this process.
2. Administrative staff will have limited confidential information such as, but not limited to name, phone number, and billing address for payment purposes. The administrative staff has been trained in confidentiality procedures.
3. 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.
4. The following are some examples of situations in which I may be required or legally permitted to disclose information without your consent or authorization:
    1. Requests made from court order
    2. 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.
5. I am considered a mandatory reporter, meaning if I suspect that any vulnerable population is being abused and/or neglected I must report to the appropriate authorities.

_____ _____

Client Signature Date

_____ _____

Care Provider'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.

Client Rights

As a client, you can expect:

- Receive care with respect, consideration, and without discrimination
- Privacy and confidentiality when seeking or receiving services except in the case of life-threatening situations or conditions
- Confidentiality of your records
- Accurate information concerning techniques, intervention strategies, and procedures
- Active participation in decisions regarding your care
- Accessible information regarding the scope and availability of services
- Information about any legal reporting requirements regarding any aspect of screening or care
- 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
- To participate by asking questions and discussing concerns throughout therapy including the therapy plan
- Option to participate in or refrain from services (except when mandated)
- Ability to request referrals for alternative services

_____ _____

Client Signature Date

_____ _____

Care Provider's Signature Date

Financial Agreement

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 indicating that you have read and agree with the information presented.

Reimbursement/Insurance Coverage

Your care provider does not accept insurance. 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 provider. 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 the balance within 30 days. If we cannot reach you to collect a payment, Valley Christian Counseling may pursue reimbursement by submitting a claim to a small claims court or hiring a collections agency. Confidential information may be shared in claims court or to collections agency on an as-needed basis.

Late Cancellation/No Show Fees

If cancellations have not been made within 24 hours of the appointment or the client does 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 the entire session fee of $65.00.

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 care provider.

_____ _____

Client's Signature Date

_____ _____

Care Provider's Signature Date

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