VALLEY CHRISTIAN COUNSELING

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. Please answer to the best of your ability.

Information you provide here will remain confidential

Please describe the reason you are seeking counseling. Include the issues and goals you desire to address and the event/s, if any, that led you to seek counseling:

_____
_____
_____
_____
_____
_____

CONTACT INFORMATION

Name: _____ Date of Birth: _____
Address:_____
City:_____ State:_____ Zip: _____
Email: _____
Cell Phone: _____ May we leave a message? Y/N:___
Home Phone: _____ May we leave a message? Y/N:___

Emergency Contact Info

In case of emergency please contact:_____
Relationship:_____
Phone:_____

PERSONAL INFORMATION

Employment

Are you currently employed? Y/N:___
If employed, where/what is your field of work? _____
If employed, are you satisfied/fulfilled in your employment? Y/N:___
If employed, what stressors do you experience due to employment?

_____
_____
_____

Religion/Spirituality

Do you consider yourself a religious/spiritual person? Y/N:___
Do you follow any particular religion? Y/N:___ If yes, which religion? _____
How often do you participate in spiritual practices?
☐Daily ☐A few times a week ☐Once a week ☐A few times a month ☐A few times a year
Would you like to include practices of religion/spirituality in counseling sessions? Y/N:___

Relationship Information

Are you currently in a relationship? Y/N:___
If yes, are you satisfied with this relationship? Y/N:___
If in a relationship, what kind of relationship is it?
(i.e., "dating", "married", "separated", etc.)_____
If in a relationship, and if stressors are present, what are the main stressors?

_____
_____
_____
_____

If not in a relationship, does that cause distress for you? Please explain:

_____
_____
_____
_____

MEDICAL/OTHER HEALTH

Medical

Do you currently have a primary physician? Y/N:___
If yes, who is your physician? _____
Are you currently seeing more than one medical health specialist? Y/N:___
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? Y/N:___
If yes, please list:

_____
_____

Sleep

Are you having any problems with your sleep habits? Y/N:___
If yes, check where applicable and describe:
☐Sleeping too little ☐Sleeping too much ☐Poor quality sleep ☐Disturbing dreams
☐Inconsistent sleep schedule ☐Other

_____
_____
_____

Would you like to explore developing better sleep habits in counseling sessions? Y/N:___

Addictive Behaviors and Substance Use

Please list any substances (legal and illegal) used in the past and/or present including alcohol, and tobacco. Please specify for each substance whether use is current or past, when the last use was, and how much was used.

_____
_____
_____
_____
_____

Have you struggled with other potentially addictive behaviors such as pornography-related behaviors, gambling, or gaming (or other)? If yes, please explain the behavior and whether the addictive behavior is current or past.

_____
_____
_____
_____

Do you want to address these behaviors in counseling sessions? Y/N:___

Suicide Safety Screener:
In the past month, have you wished you were dead or wished you could go to sleep and not wake up? Y/N:___
In the past month, have you actually had any thoughts about killing yourself? Y/N:___

Physical Activity
Would you say you are a physically active person? Y/N:___
How often do you exercise?
☐Little to no exercise ☐A few times a month ☐A few times a week ☐Nearly every day/+

GENERAL MENTAL HEALTH INTAKE

Family Mental Health History
Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? Please answer to the best of your ability and list the relationship with the closest relatives. (i.e. "Yes", experienced by "father and grandmother")
(continue on next page)

Difficulty	**Y/N**	**Family Member**
Depression	Y/N:___	
Bipolar disorder	Y/N:___	
Anxiety disorder	Y/N:___	
Panic attacks	Y/N:___	
Schizophrenia	Y/N:___	
Alcohol/substance use disorder	Y/N:___	
Eating disorder	Y/N:___	

Learning disability	Y/N:___	
Trauma history	Y/N:___	
Suicide attempts	Y/N:___	
Chronic illness	Y/N:___	
Adoption	Y/N:___	
Abuse	Y/N:___	
Other (use box to explain)		

Personal Experiences

Please mark Y/N to any of the following experiences or symptoms you have and explain briefly. (continue on next page)

Extreme depressed mood	Y/N:___	
Dramatic mood swings	Y/N:___	
Rapid speech	Y/N:___	
Extreme anxiety	Y/N:___	
Panic attacks	Y/N:___	
Phobias	Y/N:___	
Hallucinations	Y/N:___	
Unexplained losses of time	Y/N:___	
Unexplained memory lapses	Y/N:___	
Frequent body complaints	Y/N:___	
Eating disorder	Y/N:___	
Body image problems	Y/N:___	
Repetitive thoughts	Y/N:___	
Repetitive behaviors	Y/N:___	
Adoption	Y/N:___	
Learning disability	Y/N:___	

Homicidal thoughts	Y/N:___	
Suicidal attempts	Y/N:___	

Trauma Assessment
Have you experienced or witnessed any of the following? Please mark "V" if you were a victim or "W" if you were a witness.

Physical abuse	V/W:___
Sexual abuse	V/W:___
Emotional/mental abuse	V/W:___
Neglect	V/W:___
Abandonment	V/W:___
Community Violent	V/W:___
Bullying	V/W:___
Natural Disaster	V/W:___
Other (please explain below)	V/W:___

_____

On a scale of 1-10 (1 being very little or not at all and 10 being multiple times a day), how often do you have thoughts about this/these traumatic experience/s? (1-10):___

Treatment History and Expectations for Counseling
Have you received mental health counseling before? Y/N:___
If yes, was your experience overall positive or negative? Positive/Negative:_____
If you have received treatment before, what aspect of previous treatment was most helpful or most unhelpful? Please explain:

_____
_____
_____
_____
_____
_____

If this is your first time seeking counseling, what, if anything, are you most anxious about in the counseling experience? Please explain:

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?

Do you have any additional goals for therapy? If yes, please explain briefly.

VALLEY CHRISTIAN COUNSELING
Informed Consent

Overview

The following information is to assist you in establishing your expectations for counseling 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 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 canceled without 48 hours' notice, the clinician reserves the right to charge you a missed/canceled appointment fee equal to your agreed-upon session rate.

Confirmation Calls

To better serve our clients, confirmation through text and email reminders will be made to remind you of your appointment in advance. However, please make efforts to set self-reminders in the event we are not able to place a call, as ultimately clients are responsible for their appointments.

Emergency Options

If you are unable to reach our office during normal business hours and are experiencing a crisis or medical emergency please call 911 (or 988 for mental health, substance use, and suicide crises), head to your nearest emergency room, or contact Crisis Services of North Alabama at 256-716-1000 and then alert your clinician at your earliest convenience.

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 electronically stored and are compliant to all HIPPA requirements.

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. 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.

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.

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 who is 14 years old or older may seek therapeutic services without the consent or knowledge of their parents/guardians. Children who are 14 years old or older 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 mitigate any objections and explain the benefits of guardian support.

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. While I am working toward my full licensure as a Licensed Professional Counselor, I am under supervision. As such, I conduct regular consultations with my supervisor where we make every effort to ensure your confidentiality. Additionally, I may request permission for periodic observations that require consent for the purpose of providing quality care for your child. You have the right to deny the observation.

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: 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.

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.

_____	_____
Print Client Name	Date
_____	_____
Client Signature	Date
_____	_____
Clinician's Signature	Date

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 the entire session fee of $80. Grace is often offered, especially in unforeseen circumstances. Your practitioner asks for communication and in response fees may be waved 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