Counseling Agreement

As part of the counseling process, I understand that I may be required to follow through with homework exercises such as reading, changing behaviors, praying, or other initiatives that will serve my best interest. Ultimately I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling. ________ Initial

I further understand that my progress will be a direct result of my honesty, the work that I will put into resolving my issues and my willingness to move forward even if it is painful and difficult. _________ Initial

I understand that my communication with my counselor is strictly confidential and will not be released to anyone without my consent, unless I am in violation of codes of abuse – physical or sexual, a harm to myself or others. By law, my counselor is required to report such exceptions to the proper authorities in order to protect myself and/or those in danger. ______Initial

Additionally, my counselor may consult with another therapist regarding my case. This therapist will also be bound by the same confidentiality laws, that being said, my name and identity will remain anonymous. _______Initial

I understand that I will pay in full for each session (**50 minutes**). The rate is $85/session. I understand that I will pay a **$25 cancellation fee** for appointments not cancelled with **24 hours notice**. You may notify your therapist by phone or email to cancel or reschedule.
________Initial (954)755-7767 x105, Counseling@cbglades.com

Finally, although we meet in a church setting, I understand that when I see my counselor outside of the counseling sessions that is her time of worship and she will not discuss my sessions outside of my scheduled visits. ________ Initial

I acknowledge that I have read this agreement in its entirety and agree to the conditions set forth.

____ Date _______________________

(Client or Parent Guardian Signature)

____Printed Name

____Printed Name

Student Intake Form

CONFIDENTIAL

Name ____________________________________ Today's Date _____________

Contact information

Address: ____

City: _______________________ State: ____________ Zip: ________

Phone number:___________________(cell)____________________(home)

____________________(work) Date of birth ____________________

Email address: ______________________________

May I leave a voicemail on your cell or home number? Yes or no (circle your primary choice)

May I email you regarding your sessions? yes or no

Emergency (Parent) Contact : _________________________ (name) ______________(number)

How did you hear about our counseling services? Pre-service slide, service, flyer, guest services desk, a Life Group, website, friend, or other? (circle one)

Relationship

Single Dating (circle one)

Work / Educational History

Are you employed? FT, PT, unemployed (circle one)

What type of work do you do? ____

Are you a student? Yes ____ No ____

If yes, where? ______________________________ Grade level? ______________

Present area of Concern:

What is the primary reason that brings you here today? _____________________________

____

____

How long has this been a problem for you?

____

____

What do you hope to accomplish through counseling? ________________________________

____

____

What have you done already to deal with the difficulties? ____________________________

____

____

What are some of the pressures that you are currently experiencing? _________________

____

What do you think are some of the sources of these pressures? _____________________

____

Have you received counseling in the past? (yes or no) If yes, briefly discuss the nature, duration and outcome. ____

____

____

____

What would you identify as your strengths overall? _________________________________

____

____

Spiritual History

Briefly describe your spiritual relationship with God (if any): __________________________

____

____

____

Physical History

Are you presently under the care of a medical doctor? _______ If so, please list name
________________________________ contact # ___________________.

Your physician will **not** be contacted without your written consent.

Are you presently on any medication? _______ If so, please list all and frequency:

____

____

Have you experienced any past physical or emotional trauma? _______ if so, briefly describe

____

____

____

Emotional Status

Are you currently experiencing strong emotions? _____ If yes, describe_______________

____

Do you make decisions based on your emotions __________ How well does that work for you?
____

Have you had any thoughts of suicide? ______ If so, when _________________________

Do you have any thoughts of suicide now? _________________

Please respond to each of the following symptoms by indicating in the boxes provided how much of a problem they have been in the last two weeks using the following scale:
1-Serious Problem
2-Moderate Problem
3-Minor Problem
4-Not a problem

_____Depressed Mood _____Anxious/Nervous _____Anger

_____Problems w/sleep _____Decreased appetite _____Racing thoughts

_____Excessive worry _____Poor judgment _____Compulsive behavior

_____Fatigue _____Increased appetite _____Sweats/chills

_____Social withdrawal _____Impulsive behavior _____Irritability

_____Low self-worth _____Feelings of Hopelessness

Relational History

Do you have siblings? __________ If yes, please list names and ages:

Name

_____________________________________ Age _______________

_____________________________________ Age_______________

_____________________________________ Age_______________

_____________________________________ Age_______________

Do you feel like you have a good relationship with your siblings? _____________ Please explain:

____

____

Do you feel that you can speak openly to your mother? Explain.____________________________

____

Do you feel that you can speak openly to your father? Explain. ____________________________

____

Do you currently reside in the same household as your family members? _________

If yes, please list the members living with you

____

____

Other

Is there anything else that is important for me as your therapist to know, and that you have not written about on any of these forms? If yes, please discuss here:

____

____

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