CLIENT INFORMATION—ADULT

(Revised October 2018)

Today's Date: _____

Client Name: _____ Form Completed By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone (cell) (work): _____

E-Mail: _____ (Confidentiality of email communication cannot be guaranteed.)

Date of Birth: _____ Gender: Male _____ Female _____

Employment: Full-time _____ Part-time _____ Not employed _____ Student _____

Occupation_____ Employer/School_____How Long? _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

General Information

Have you ever sought help in counseling or psychotherapy before? Y N

Provider's name: _____

Date of service: _____

Are you currently working with another counselor? Y N

Provider's name: _____

Have you ever been treated by a psychiatrist? Y N

Provider's name: _____

Date of service: _____

Have you ever been hospitalized for a mental health reason? Y N

Date of hospitalization: _____

How did you find out about NLC/ABCS? (please circle)

Yellow Pages Pastor/church Physician Friend Internet

Family of Origin Information

By whom were you raised? (Please circle)

Both parents mother father grandparent other

Were your parents married to each other? Y N

Did they remain married? Y N

Your age at their divorce, separation or death:_____

How many siblings do you have? _____

Where are you in the birth order? _____

Which best describes the atmosphere of the home in which you grew up (please circle all that apply):

Nurturing Calm Neutral Conflicted Angry Abusive Loving Emotionally volatile

Relational Information

Current relational status:

Single, never married: ____ in relationship _____ not in relationship

Married: Name of spouse or significant other:_____

Anniversary date:_____

Separated: Date of initial separation:_____

Divorced: Date of final divorce decree:_____

Cohabiting: When began:_____

Indicate number of marriages/cohabitations (including current one): _____

Which best describes your current relationship (please circle all that apply):

Abusive bland calm conflicted loving satisfying unfulfilling

Please list those with whom you currently live:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Information

Doctor: _____ Telephone Number:_____

Are you currently under a doctor's care? Y N

If yes, please explain: _____

_____

May we contact your physician? Y N

List medications:_____

Please list any significant medical conditions (HBP, Gastric Reflux, Fibromyalgia, etc.):

_____

Are you having trouble sleeping? Y N

Do you have trouble getting to sleep? Y N

Do you have trouble staying asleep? Y N

Do you have recurrent dreams or nightmares? Y N

Do you have trouble concentrating or getting organized? Y N

Have you noticed a recent change in your weight in the last 3-6 months? Y N

Gain or loss? How many pounds?_____

Have you noticed a recent change in appetite? Y N

Increase or Decrease?

Have you noticed a recent change in your sexual desire? Y N

Increase or Decrease?

Do you have any unexplained crying spells? Y N

Do you often feel any tightness in your chest or throat or heart palpitations? Y N

Do you often feel "nervous" or "anxious"? Y N

Do you often complain of headaches or stomach aches? Y N

Substance Use Information

What is your current substance usage, including alcohol and caffeine:_____

_____

Do you recognize any addictions in your life (alcohol, drugs, gambling, sex, internet, work)? Y N

Please describe: _____

Emotional Information

Do you ever feel like running away? Y N

Do you ever feel like hurting yourself? Y N

Have you ever attempted suicide? Y N

Have you recently suffered a significant loss (job loss, death, divorce, etc) Y N

Who? _____ When? _____

Do you believe you have ever been a victim of abuse (emotional, physical, sexual, verbal)? Y N

Where? _____ When? _____

Please describe: _____

Are you happy with your job or classes? Y N

Do you have a "best friend?" Y N

Who? _____

What do you do for fun? _____

Spiritual Information

What is your spiritual/religious background? _____

Do you practice any type of religion or spirituality? (Please circle) Y N

Buddhism Christianity Mormonism Islam Judaism Other

Are you a member of a local church, mosque or synagogue? Y N

Congregation:_____

How often do you attend? _____

Do you have a favorite Bible story, verse or character? Y N

If yes, please explain:_____

How do you maintain or nurture your spiritual life? _____

_____

Presenting Concerns

Please describe the reason(s) for which you are seeking counseling at this time:

_____ _____

Client Signature Date

TREATMENT GOALS AND PHILOSOPHY

New Life Counseling is a Christ-centered, biblically based counseling ministry of Arizona Baptist Children's Services. We serve individuals, children, couples and families who are looking for new answers to old problems. Our goal is to help clients move beyond their current struggles to a place of peace and healing by providing effective solutions and coping strategies. These strategies are based on Christian principles integrated with recognized counseling techniques to help guide people to a meaningful relationship with God and others.

AVAILABLE SERVICES

New Life Counseling is an outpatient provider that employs counseling modalities which assist individuals, couples, and families in resolving their difficulties. **Counseling sessions are 45 to 50 minutes in length**.

CANCELLATION NOTICE or "NO SHOW" APPOINTMENTS

A 24-hour notice is required when canceling or rescheduling an appointment *except* in cases of an emergency. Your counselor reserves the right to determine what constitutes an emergency. A $50 fee will be assessed for any "no show" or a rescheduled appointment with less than 24 hours notice. Arriving 15 minutes or more late to a scheduled appointment will be considered a "no show" appointment. If payment for services is handled through a third-party and the third-party does not cover the late cancellation fee or "no show" fee, then the fee will be assessed to the client. Failure to cancel in advance two times or if the client has two "no show" appointments may result in termination of services.

FEE FOR SERVICES

Payment is expected at the time of service. Case management services (ie. staffing, communication with other professionals involved with client/family, consultations, report writing) will be prorated based on counseling fee with a 15 minute minimum. **Because we are committed to God's healing and redemption in our client's lives, we do not voluntarily provide forensic services, which are assessments, treatments or recommendations to the courts and legal community. In the unfortunate event that a judge's order is issued for our counselor's records and/or testimony, the therapeutic counseling relationship will be ended and a referral to another professional will be made.** Cases requiring court-ordered involvement with the legal and judicial system (ie. communication with attorneys, forensic research, and judge-ordered court appearances) will also be prorated at a rate equal to double the counseling fee with a 15 minute minimum.

CLIENT RIGHTS

The rights and well-being of our clients are primary concerns to the counselors of New Life Counseling. We strive to provide quality care to our clients in caring and ethical atmosphere. Each client accepted for services shall be afforded the basic right to:

- Treatment and services under conditions that support personal liberty and restrict such liberty only as necessary to comply with treatment needs
- A reasonable explanation of all aspects of one's own condition and treatment
- Be informed in advance of charges for services
- All available services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status

- Refuse treatment at any point in the treatment process
- Confidentiality of records; within guidelines of state law
- Be informed, in appropriate language and terms, of rights including the right to legal counsel and other requirements of due process
- Referral, as appropriate, to other providers of behavioral health and other services

URGENT/EMERGENCY CARE

Arizona Baptist Children's Services/New Life Counseling does not provide crisis services. Your counselor will give you his or her emergency contact information. If you are in need of crisis services you are encouraged to contact the local crisis center, go to the nearest emergency room or call 911 for assistance.

PARENT RESPONSIBILITY

Parents/guardians are responsible for supervising their children at all times while at the New Life Counseling office. Parents/guardians are financially responsible for any damages their children may cause while in the office or public restrooms.

NO WEAPONS POLICY

No weapons are allowed on the premises of New Life Counseling or in your possession during sessions with representatives of New Life Counseling. Our staff will take the necessary reporting steps in the event that you are found to be in possession of any type of weapon. This strict policy is designed to ensure the safety of everyone.

NO ALCOHOL OR STREET DRUGS

Do not attend counseling sessions if you have taken alcohol or street drugs.

CUSTOMER SATISFACTION SURVEY

When you are discharged you will be asked to fill out a client satisfaction survey or the survey will be mailed to you. This allows you to comment on the quality of your services at New Life Counseling. We strongly encourage you to honestly fill out this survey to provide us with information to improve the quality of our services.

_____ _____

Client Signature Date

FINANCIAL AGREEMENT

NEW LIFE COUNSELING offers Christ-Centered, Biblically-Based counseling at an affordable rate. Standard fees are $80 per 50 minute counseling session. (Some counselors will schedule 75 minute sessions for family or marital counseling – fees for these sessions are 1 ½ times the standard rate at $120.) Unfortunately, AZ law does not allow NLC to accept health insurance, AHCCCS, Medicare or Medicaid as payment for services.

Fees for Marriage or Pre-Marital counseling packages which include a Prepare-Enrich assessment are as follows:

- Prepare-Enrich Assessment and one (1) counseling session - $150
- Prepare-Enrich Assessment and three (3) counseling sessions - $300

A minimum of one half the cost of the package is due when sessions are scheduled, as some preliminary work is required of your counselor in these instances.

Payment is expected at the time of service unless other arrangements have been made. Third-party payments (from the client's church, employer or sponsoring individual) will be billed as agreed upon between myself and my counselor. If an agreed upon third-party does not pay, I will be responsible to pay the sliding scale fees. I understand that I will be informed in advance of any changes in the agreed upon fees for service.

Accepted method of payments include: cash, credit, debit, or personal check. Checks are to be made payable to ABCS/NEW LIFE COUNSELING. Donations to ABCS/NEW LIFE COUNSELING are tax deductible, but counseling fees are not.

If you must cancel a scheduled appointment, you must provide at least 24 hours-notice. If you experience a scheduling emergency, call your counselor as soon as possible. If you do not provide adequate notice or attend your scheduled appointment, you will be billed $50.00 for the missed appointment.

I _____agree to pay (please check one):

____$80 per session

____$300 includes Prepare & Enrich assessment plus three (3) sessions

____$150 includes Prepare & Enrich assessment plus one (1) session

I have read, understand and agree to the above financial policies.

_____ _____
Client Signature Date

_____ _____
Counselor Signature and Credentials Date

INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with ethical standards, the counselor is required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside our ministry when he/she feels it will facilitate the work with you/your family. Your name and any uniquely identifying information about you/your family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let your counselor know if you are withholding consent.**

Professional Records

The laws and standards of counseling require the keeping of case records. Records are locked and kept on site. You are entitled to receive a copy of your records or a summary of your care if you make a written request. These request forms for the summary of your care are available to you. Please note that these are professionally-held records and can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records it is recommended that you review them with your counselor so that the contents can be discussed. You have the right to amend your record, if you find something disagreeable or concerning. Your record will NOT be disclosed to others unless you ask the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information. Meetings will be scheduled at mutually convenient times.

AUTHORIZATION TO TREAT

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

_____

Client Name

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Presented to: _____
Client Printed Name

For: _____
Client Printed Name

Presented by: _____
New Life Staff Printed Name

I, _____, hereby acknowledge that I have received and read the Notice of Privacy Practices for Arizona Baptist Children's Services and that their staff was available to answer any questions I had and to offer further clarification of the contents of the Notice. * *You may refuse to sign this acknowledgment**

Signature: _____ **Date:** _____
Client Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining the acknowledgement

____ Other (Please Specify) _____

Arizona Baptist Children's Services Staff Signature: _____

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