Intake Survey & Therapy Agreement

Today's Date: ______________________

PERSONAL INFORMATION

Print Full Name: ____

Last First Middle

Local phone: ______________________ Cell phone: ______________________

Email: ____

Address: ____________________ City/State ________________ Zip ________

Age: ______ Date of Birth: ____________ Sex: M / F

Print Full Name of Spouse: ____

Last First Middle

Local phone: ______________________ Cell phone: ______________________

Email: ____

Address: ____________________ City/State ________________ Zip ________

Age: ______ Date of Birth: ____________ Sex: M / F

WORK/SCHOOL (IF APPLICABLE)

Place of Employment: ______________________ Department: ____________

Phone: ______________________ How many hours per week? ____________

School: ______________________ Grade/Year: ____________

REASON FOR SEEKING THERAPY

1. Briefly describe your reason for coming: ____

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2. Who suggested you contact us? ____

3. List medication currently taking and reason for medication.

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PUT INITIALS BESIDE THOSE THAT ARE A CURRENT PROBLEM FOR EACH OF YOU. UNDERLINE ANY THAT HAVE BEEN PAST PROBLEMS.

_____ Suicidal thoughts	_____ Feelings of Inferiority	_____ Change of appetite
_____ Homicidal thoughts	_____ Sexual problems	_____ Marital problems
_____ Depression	_____ Pornography	_____ Family problems
_____ Unhappiness	_____ Alcohol use	_____ Dating problems
_____ Stress	_____ Drug use	_____ Gender Identity issues
_____ Fears	_____ Physical abuse	_____ Poor social relationships
_____ Anger	_____ Sexual abuse	_____ Insomnia
_____ Death & Grief	_____ Emotional abuse	_____ Excessive sleep
_____ Guilty feelings	_____ Self injury behavior	_____ Vomiting
_____ Spiritual concerns	_____ Body image concerns	_____ Poor self discipline
_____ Procrastination	_____ Physical health problems	_____ Lack of ambition/goals
_____ Loneliness	_____ Nightmares	_____ Career/Major choice
_____ Adjusting to college life	_____ Tiredness	_____ Internet abuse
_____ Academic problems	_____ Headaches	_____ Media abuse

Briefly describe anything else you want your counselor to know about you.

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SERVICES AND FEES

Cedar Rock Ministries' counseling services are provided by Nick Fouts, a Licensed Associate Counselor in the State of Arkansas with an MS degree in Marriage and Family Therapy. Occasionally, Nick's wife, Renee Fouts, who has her certificate in Spiritual Direction, will serve in the role of co-counselor if agreed upon by all parties involved.

Fees for one session are $125.

CONFIDENTIALITY STATEMENT

Perhaps the most critical factor in a therapeutic relationship is confidentiality. Much of what you may wish to share with your counselor is very personal. We, as health care professionals affirm your right to privacy. Information shared during a counseling session can only be shared with an appropriate outside party(s) if one or more of these criteria are met:

1. You sign a written release of information permitting such disclosure.
2. Supervisory purposes – if your counselor is a sub-doctoral level staff member or trainee. (Note: Supervision is always provided by a licensed professional via chart notes, tests, video and/or audiotape).
3. You are assessed as being potentially harmful to yourself or others.
4. You are assessed as being emotionally disturbed to the point of being unable to care for yourself.
5. You reveal information about abuse or neglect of minors or the elderly.
6. Records are ordered by a court of law.
7. A summary of records is requested by your insurance company or managed care company.

I understand the terms of services, fees and limits of confidential information shared with my counselor.

Client signature(s) ____ Date ____________________

____ Date ____________________

Counselor's signature ____ Date ____________________