Jennifer Christian Counseling

Courage Heal Live

New Client Intake Form

For Confidential Use Only

Date: ________________

Name: ____ Date of Birth: ______________

Referred by: ____

Home Address: ____

Street City Zip

Home Phone: ______________________________ Cell Phone: ______________________________

Work Phone: ________________________ May we contact you at work? Y N

May we leave you a message? Home phone: __________ Cell phone: _________ Work phone: ________

Email address: _________________________________ May we email you? Y N

Emergency Contact: ______________________________________ Phone: ______________________

(Signature of this document indicates consent to contact this person in case of an emergency)

Primary Care Physician: _________________________________ Date last seen: _________________

Current diagnosis or medical concerns: ____

____

____

Please list all medications: ____

____

____

Brief statement of your reason for seeking therapy at this time and what you would like to accomplish:

____

____

____

How would you rate the intensity of the problem or concern?

1 2 3 4 5 6 7 8 9 10

Past Counseling History:

Date	Length of Service	Agency & Therapist
________________	______________________	______________________
________________	______________________	______________________

Occupational Status

Occupation: ___________________________ Employer/School: ____________________

Number of years (or highest level of education) ____________________

Primary Household Information
(Continue on back if needed)

Marital Status: Single: ____ Married: ____ Divorced: ____ Widow(er): ____ Cohabitating: ____ Other: ____

Persons living in household

Name	Age	Gender	Relationship
____________________________	________	________	________________
____________________________	________	________	________________
____________________________	________	________	________________
____________________________	________	________	________________

Religion: ___________________________

Is it important for you to have your spirituality included in your therapy: Y N

Describe any concerning eating or sleeping habits: ______________________________________

____

____

Have you experienced any traumatic situations? Y N (If yes, please explain):

____

____

____

____

Have you ever thought about hurting yourself or another person? Y N

Please describe: ____

____

History of medication, alcohol or illegal drug use or dependence: Y N

Please describe: ____

____

____

History of domestic violence, child abuse, or sexual abuse in your family: Y N

Please describe: ____

____

____

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No___If Yes, enter 1 __

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __

6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 __

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 __

10. Did a household member go to prison?
    No___If Yes, enter 1 __

Please check any past, present, or anticipated circumstances with an "X" and brief explanation:

- ☐ Serious Illness ____________________
- ☐ Depression ____________________
- ☐ Fatigue ____________________
- ☐ Grief or significant loss ____________________
- ☐ Loss of temper ____________________
- ☐ Mood swings ____________________
- ☐ Nervousness ____________________
- ☐ Phobias (fears) ____________________
- ☐ ADHD or ADD ____________________
- ☐ Psychiatric Disorder ____________________
- ☐ Legal Problems ____________________
- ☐ Unemployment or high job stress ____________________
- ☐ Suicidal thoughts/self injurious behaviors ____________________
- ☐ Other not listed ____________________

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Current Client Symptoms: Please rate all that apply from 1 to 3 (1-Low, 2-Moderate, 3-High Concern)			
☐ Family problems	☐ Feel sad or depressed	☐ Anxiety/worry	☐ Hear strange things
☐ Marital/relationship issues	☐ Cry often	☐ Stress	☐ See strange things
☐ Trouble communicating	☐ Feel hopeless	☐ Extreme fear	☐ Wanting to hurt others
☐ Physical or sexual abuse	☐ Anger problems	☐ Panic attacks	☐ Suicidal thoughts
☐ Domestic violence	☐ Frustration	☐ Aggressive behaviors	☐ Others are out to get me
☐ Sexual problems	☐ Trouble concentrating	☐ Nightmares	☐ Thoughts of Death
☐ Intimacy issues	☐ Trouble sleeping	☐ Upset stomach	☐ Wanting to hurt myself
☐ Divorce	☐ Feel guilty	☐ Health Problems	☐ Legal problems
☐ Pre-marital counseling	☐ Low self-esteem	☐ Severe pain	☐ Financial problems
☐ Grieving	☐ Loss of appetite	☐ Headaches	☐ Smoke cigarettes
☐ Lack of sex drive	☐ Dramatic weight changes	☐ Sweating	☐ Alcohol use
☐ Spiritual Issues	☐ Feel tired or low energy	☐ Trouble breathing	☐ Drug use
☐ Can't make friends	☐ Lack of motivation	☐ Quick mood changes	☐ Restless/Can't sit still
☐ Feel Lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating Disorder	☐ Other:___________

Please list or describe any symptoms: ____

____

____

____

New client intake form completed by:

_______________________________________ _______________________________

(Signature of Client) Date

_______________________________________ _______________________________

(Signature of authorized adult if client is a minor) Date

Professional Service Agreement

Welcome. Thank you for choosing Jennifer Christian Counseling. My goal is to provide you with therapy services and tools that can help you manage and improve your quality of life. Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, and behaviors. You determine the nature and amount of change you wish to make. Most people experience improvement or resolution to the concerns that brought them to therapy, but there are no guarantees; and, some risk is involved. For example, therapy could open up new levels of awareness that cause discomfort as traumas and/or conflicts are discussed. Homework assignments as part of the changing process may require you to move outside your comfort zone. If this happens, please be sure to discuss this with me during your session. I understand that this is part of the process, and I am here to help you.

Training and professional background: I am a Licensed Professional Counselor, licensed by the Texas State Board of Examiners of Professional Counselors. I am a member of the American Counseling Association, Texas Counseling Association, and the International Centre for Excellence in Emotionally Focused Therapy. I have a master's degree in Counseling Psychology with a specialization in Marriage and Family Therapy from the University of Texas in Tyler. I have also completed EMDR Approved Basic Training, Emotion Focused Couple's Therapy Externship, and Advanced Emotion Focused Couples Therapy Core Training.

The rights of clients in counseling: It is appropriate for clients to raise questions about the counselor, the therapeutic approach, the progress of therapy and the cost. As an informed consumer, it is the client's responsibility to choose the counselor and counseling approach that best suits their needs. Clients have the right to request a change in the counseling approach, refer to another counselor, or terminate at any time.

Termination Protocol
Should Jennifer Christian, LPC become incapacitated or deceased while a client is undergoing treatment, Amy Fuller, PhD will properly dispose of client record and ensure continuation of care.

Informed Consent

This Professional Service Agreement outlines my policies and procedures for Jennifer Christian Counseling. The following information is important. Please take time to read and initial the paragraphs below stating that you agree and understand my policies and procedures. You are more likely to meet your goals when you understand the nature and limitation of counseling.
_________**Emergency/Crisis**: Please be aware that Jennifer Christian, LPC does not provide a 24-hour crisis counseling service. Should you experience an emergency needing immediate mental health attention, call 911, or go to the nearest emergency room for assistance.
________**Confidentiality**: All communications become part of the clinical records and are property of Jennifer Christian, LPC. All information shared will be kept confidential. Both verbal information and written records cannot be shared with any other person(s) without my written consent or, if a minor, the minor client's legal guardian. I understand that the following are exceptions.

- Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care

professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

- Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child or vulnerable adult, or has abused a child or vulnerable adult recently, or a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. This includes domestic violence that a child is exposed to, and prenatal exposure to substances that are potentially harmful.
- Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the client's record.
- Insurance Providers (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients.
- Court Subpoena: If I receive a court subpoena for your records.

________**Professional Relationship**: While sessions might be psychologically intimate, it is important for you to understand that the relationship is strictly professional. Contact will be limited to counseling sessions only. You will best be served if the relationship remains strictly professional.

________**Childcare Unavailable**: Please arrange for small children to remain at home unless specifically asked to bring them as a part of family therapy. Children may not be left unattended. Failure to do this will result in the appointment being rescheduled, and being charged a cancellation fee.

________**Fees and Length of Therapy**: I agree that I am responsible for payment of services for this account, or in the case of therapy for a minor, that I as the guardian am responsible for payment. The fee per counseling session is $145 for a 60 minute session. I ask that you make payment in full at the end of each session. If your account becomes two sessions past due, my policy is not to schedule additional appointments until payments are current.

________**Insurance**: I do not take insurance. However, I can submit to your insurance just in case there is a possibility of some reimbursement. Note: If you are using insurance, it is a good idea to check with your insurance provider and verify your out-of-network mental health benefits first.

________**Cancellation or Missed Appointments**: I understand that situations arise that may prevent you from keeping a scheduled appointment. As a courtesy, please notify me at least 24 hours in advance of your appointment if you cannot keep it. Except for emergencies, if you fail to show up for your scheduled appointment and do not call, a regular session fee will be filed to you, or charged to your credit card if one is on file.

________**Court**: It is in your best interest to know that conducting an expert witness/testimonial service is not in my area of interest or expertise. I do not agree to serve as an expert witness or to provide testimonial services for you, and you agree to not use my services in this way. If you are seeking counseling for court related purposes, I will provide you with alternative appropriate referral sources. Should you, your attorney, or the attorney of your spouse or ex-spouse subpoena me or your client file, or involve me in a court related process, you agree to pay $500 for every hour of my time involved including case preparation, travel, witness and wait time related to a court related process. You further agree to pay a retainer fee of $2,000 at the time the subpoena is served. All subpoenas will be turned over to an attorney at your expense.

________**Social Media Policy**: Jennifer Christian does not accept or solicit friend requests from current or former clients on any PERSONAL networking site. Adding clients as friends or contacts on social network sites can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship.

________**Communication Policy**: It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS"), or other electronic methods of communication. Be informed that these methods in their typical form are not confidential means of communication. If you use these methods to communicate with Jennifer Christian a reasonable chance exists that a third party may be able to intercept and/or eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with Jennifer Christian.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.
- If you do not want certain people accessing these communications, please talk with your therapist about ways to keep your communications safe and confidential.

Consent for Transmission of Protected Health Information by Non-Secure Means

________ I consent to allow Jennifer Christian, LPC to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Information related to resources discussed during session

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

______________________________ ______________________
(Signature of client) Date

General Consent for Therapy and Services

I consent to counseling as prescribed by the therapist, Jennifer Christian, LPC. I have read, understood, and initialed the above Professional Service Agreement. I understand that I am encouraged to ask questions and give input regarding the therapy process at anytime. If there is anything in this form that I do not understand, it is my responsibility to seek clarification before signing. By signing this document, I acknowledge that I have read, understand, and agree to the policies and procedures outlined by Jennifer Christian, LPC.

______________________________ ______________________
(Signature of Client) Date

______________________________ ______________________
(Signature of authorized adult if client is a minor) Date