

Informed Consent

Client Name(s): _____

I am aware that Arkansas Baptist Children's Home and Family Ministries (ABC Homes) provides faith-based professional counseling services from licensed mental health professionals or Pastoral counselors in the process of becoming licensed. We invite you to ask your counselor to explain their credentials, specializations and training. Furthermore, my signature and initials attest that I have the ability and am willing to voluntarily consent to counseling and can at this time make rational decisions on my own behalf.

Initial here if this section has been read and understood ____|____

Risks and Benefits:

I am aware that there are both risks and benefits to counseling. While most people experience some level of distress that leads them to seek counseling, it should be understood that when a counselor and client are working towards the goals of counseling, distress, problems in relationships, and other unforeseen circumstances may arise. It is also understood that a goal of counseling will be to alleviate or manage these potential stressors, but an exacerbation of problems may occur. The benefits of therapy may include, but are not limited to, the diminishing of symptoms, distress, relationship growth and a general sense of well-being. However, individual results are not predictable and may vary.

Initial here if this section has been read and understood ____|____

Exceptions to Confidentiality:

I understand that I waive my right to confidentiality...

1. When a counselor makes an assessment of a foreseeable suicide risk.
2. When a client acknowledges past or present instances of incest, child molestation, rape, child or elder abuse.
3. When the client reveals intentions to commit a crime or when they can be accurately assessed as dangerous to themselves or other members of society.
4. When counseling records are subpoenaed by a court of law.

I have read the preceding statements and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances my counselor is bound both ethically and legally to inform the proper authorities.

Initial here if this section has been read and understood ____|____

Release of Information:

- I do not authorize any release of information at this time.
- I authorize release of information to the following person(s): (list on following page)

Name	Relationship	Contact Information

Would it be acceptable for your counselor to send a note of appreciation to your pastor or referral source indicating that you have initiated counseling?

Yes___ No___ Referred by _____

(This note will not release any information other than the fact that you have initiated counseling. Any further contact with your pastor or referral source would require your authorization.)

Initial here if this section has been read and understood ____|____

Emergency Notification:

My counselor can be called in the case of psychological emergencies. However he will not always be available by phone or in the evenings. If I cannot reach my counselor I can call 911 or go to the nearest emergency room.

Initial here if this section has been read and understood ____|____

In Case of Emergency:

I would like the counselor to contact _____ at this phone number (____)_____

Initial here if this section has been read and understood ____|____

Submission to treatment:

- I have read and understand the above information and agree to receive counseling from ABC Homes.
- I submit my minor child/children to counseling. If applicable, a copy of custodial documentation must be provided prior to treatment of a minor.

Signature of Consenting Client(s)/Guardian: _____

Date: _____

Counselor's Signature: _____

Personal Information

Client Name _____ **Date of Birth** _____ **Age** _____

Responsible Party _____ **Date of Birth** _____ **Age** _____

Physical Address _____ **City** _____ **State** _____ **Zip** _____

Mailing Address (if different from physical address) _____

City _____ **State** _____ **Zip** _____ **E-mail** _____

Home Phone _____ **Work Phone** _____ **Cell / Other** _____

Birthplace _____ **Place of Employment** _____ **Occupation** _____

Last Grade Completed _____ **High School Diploma/GED** **College Degree** **Graduate Degree**

Ethnicity:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Asian / Pacific Islander | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> African American | <input type="checkbox"/> Other |

Marital Status (indicate # of yrs): Married _____ Divorced _____ Widowed _____
 Separated _____ Engaged _____ Cohabiting _____ Single

Spouse's Name _____ **Date of Birth** _____ **Age** _____

Spouse's Place of Employment _____ **Work Phone** _____

List all others living in your home:

Name	Age	Birthday	Relationship (ex. son, daughter)	School or Place of Employment

Problem/Symptom Checklist

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Alcohol / Drugs | <input type="checkbox"/> Family | <input type="checkbox"/> Marriage | <input type="checkbox"/> Singleness |
| <input type="checkbox"/> Aging | <input type="checkbox"/> Fear | <input type="checkbox"/> Money/Budgeting | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Finances | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> God / Faith | <input type="checkbox"/> Other Addiction | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Co-Dependency | <input type="checkbox"/> Grief / Loss | <input type="checkbox"/> Parenting | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Child Custody | <input type="checkbox"/> Guilt | <input type="checkbox"/> Past Hurts | <input type="checkbox"/> Weight Control |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Premarital | <input type="checkbox"/> Work / Career |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Intimacy | <input type="checkbox"/> School / Learning | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> In-laws | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sexual Issues | <input type="checkbox"/> Other _____ |

History of the Presenting Problem or Complaint

State the nature of your problem: _____

What do you want to accomplish during your sessions? _____

Why are you coming at this time? _____

Who is coming for counseling? _____

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

How did you hear about us? _____

Medical History

Any hospitalizations within the last five (5) years; _____

Have you ever received psychiatric or psychological help or counseling of any kind before? Yes No

Rate Your Physical Health: Very Good Good Average Declining Poor

Recent Weight Changes: Gained _____ Lost _____

Check if Applicable: Difficulty Sleeping Difficulty Eating Headaches

How many hours of sleep do you average each night? _____

Current Medical Conditions (ex. high blood pressure, asthma, chronic pain, etc.):

Please list any medications you are currently taking even if they were not prescribed for you:

Name	Dosage / How Often	Reason Taken	How Long Taken	Response / Side Effects
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Please list any medications that you have previously taken for anxiety, nervousness, depression, or related types of problems.

Name	Dosage / How Often	Reason Taken	How Long Taken	Response / Side Effects
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Caffeine Usage: Please specify the amount of any of the following products with caffeine that you drink or use within a typical 24 hour day.

Cola Beverage _____ Brewed Coffee _____ Instant Coffee _____
 Tea _____ Energy Drinks _____ Caffeine Pill _____
 Chocolate Beverage _____ Chocolate Candy _____ Other _____

Have you ever experienced any of the following?

- Physical Abuse
- Emotional Abuse
- Spousal Abuse
- Sexual Abuse
- Rape
- Harsh Physical Punishment as a child
- Incest
- Sexual advances towards you as a child
- Other _____

If so, please explain _____

Crisis Information:

- Any current suicidal thoughts, feelings, or actions? Yes No
- Any current homicidal thoughts, feelings, or actions: Yes No
- Do you have a history of anger or impulse control problems? Yes No
- Have you experienced the death of a loved one within the last five (5) years? Yes No
- Have you experienced any other significant losses within the last five (5) years? Yes No
- If yes, please explain _____

- Have you ever been arrested? Yes No If yes, please explain _____
- Have you ever served time in jail? Yes No If yes, please explain _____
- Do you currently use any illegal drugs or other substances including marijuana? Yes No
- Have you ever used any illegal drugs or other substances including marijuana? Yes No
- Do you smoke or use tobacco products? Yes No
- Do you drink alcoholic beverages including beer, wine, or liquor? Yes No

Religious Background

- Do you consider yourself a religious person? Yes No Uncertain
- Do you believe in God? Yes No Uncertain
- Do you pray to God? Often Never Occasionally
- Are you saved? Yes No Not sure what you mean
- Do you read the Bible? Often Sometimes Never
- Meaningfulness of your faith/religion: High Medium Low
- Religious Affiliation: *Childhood* _____ *Adolescence* _____ *Now* _____
- Church you attend. _____

Household Annual Income Level and Recommended Sliding Scale Rate per Service:

- \$0 to \$10,000 (\$2.50)
- \$10,000 to \$20,000 (\$5.00)
- \$20,001 to \$30,000 (\$10.00)
- \$30,001 to \$40,000 (\$20.00)
- \$40,001 to \$50,000 (\$25.00)
- \$50,001 to \$60,000 (\$30.00)
- \$60,001 to \$70,000 (\$35.00)
- \$70,001 to \$80,000 (\$40.00)
- \$80,001 or above (\$45.00)



***Counseling services are a ministry provided by ABC Homes. No person, couple or family will be turned away for lack of providing financially toward their care**

Marriage Information:

Is your spouse willing to come to counseling? Yes No
Have you ever been separated? Yes No
Have either of you ever filed for divorce? Yes No
Date of Marriage_____ Your ages when married: Husband_____ Wife_____
How long did you know your spouse before marriage? _____
How long did you date your spouse? _____
How long were you engaged? _____

List two important requests you have for your spouse at this time.

1. _____ 2. _____
How frequently do you make this request?_____ What is your spouse's response?_____

List two important requests your spouse has for you.

1. _____ 2. _____
How frequently does he/she make this request?_____ What is your response?_____

Have any of your family members ever received psychiatric or psychological help or counseling of any kind before? Yes No

Do any of your family members have a history of mental illness? Yes No If yes, please explain whom and the nature of the illness. _____

Family Background Information:

Father: First Name_____ Age_____ Occupation_____
State of Health_____ Resides in_____
If deceased, how and when_____
List three words that best describe him (ex. loving, mean, etc.)_____
How do/did you get along?_____

Mother: First Name_____ Age_____ Occupation_____
State of Health_____ Resides in_____
If deceased, how and when_____
List three words that best describe her (ex. loving, mean, etc.)_____
How do/did you get along?_____

Stepfather: First Name_____ Age_____ Occupation_____
State of Health_____ Resides in_____
If deceased, how and when_____
List three words that best describe him (ex. loving, mean, etc.)_____

How do/did you get along? _____

Stepmother: First Name _____ Age ____ Occupation _____
 State of Health _____ Resides in _____
 If deceased, how and when _____
 List three words that best describe her (ex. loving, mean, etc.) _____
 How do/did you get along? _____

Your happiest memories of family and childhood are? _____

Your most unpleasant memories of your family and childhood are? _____

Sibling Relationships (Including yourself, Please list in birth order).

First Name	Age	Where Resides	Relationship Now
			<input type="checkbox"/> Close <input type="checkbox"/> Distant <input type="checkbox"/> In Between
			<input type="checkbox"/> Close <input type="checkbox"/> Distant <input type="checkbox"/> In Between
			<input type="checkbox"/> Close <input type="checkbox"/> Distant <input type="checkbox"/> In Between
			<input type="checkbox"/> Close <input type="checkbox"/> Distant <input type="checkbox"/> In Between
			<input type="checkbox"/> Close <input type="checkbox"/> Distant <input type="checkbox"/> In Between
			<input type="checkbox"/> Close <input type="checkbox"/> Distant <input type="checkbox"/> In Between

Intake Summary: (for Counselor)