

CLIENT INFORMATION FORM

Welcome to Faith Promise Church counseling service.

Please complete page, review office policy on separate page and sign where indicated.

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Phone _____ May we contact you at this number? Yes No

Email address: _____ May we contact you via email? Yes No

You will receive an automated appointment reminder to the email you provide, unless you opt out above.

Date of Birth: ____/____/____ Age: _____ Marital Status (circle): Single Married Divorced Widowed

Years completed in school: _____ Employer: _____

Parents are currently(circle): Married Divorced Separated Deceased

Sibling Names and Ages: _____

Names and Ages of Your Children:

Name: _____ Age: _____ Live with you? Yes No

Name: _____ Age: _____ Live with you? Yes No

Name: _____ Age: _____ Live with you? Yes No

List anyone else living with you: _____

How long have you attended Faith Promise Church? _____

Are you a Core member? Yes No If not, would you like to become part of the core? Yes No

What campus do you attend? _____

How did you find out about our Counseling Services? _____

Have you seen a counselor before? Yes No If yes, please describe dates and circumstances: _____

Have you ever been hospitalized for medical or psychiatric reasons? Yes No If yes, dates and details: _____

Do you have a current or long-term medical condition? Yes No If yes, please describe: _____

Are you currently taking medication? Yes No If yes, list medication and dosages: _____

Please describe your reasons for seeking counseling: _____

How long have these concerns been a problem? _____

What have you tried, thus far, to address these concerns? _____

CLIENT INFORMATION FORM:

- Place a circle any of the concerns you are currently experiencing:

Suicidal thoughts

Alcohol use/overuse

Anger

Anxiety

Body image Issues

Childhood Trauma: Circle all that apply:

Physical abuse, sexual abuse, emotional abuse, neglect, abandonment, etc.

Conduct Problems

Conflict with parent/guardian

Decreased Energy

Depression

Educational/School Issues

Emotional/psychological abuse

Financial Abuse

Financial Difficulties

Food/Weight Issues

Health/Medical issues

Internet Use or Overuse: Circle all that apply:

social media, gaming, spending, sexual material, etc.

Legal Issues

Loss/Grief

Marital Discord

Marijuana use/overuse

Mood Swings

Opiate/Pain meds overuse

Panic Attacks

Parenting Issues

Physical Abuse

Sleep Disturbance

Spiritual Concerns

Stress

Substance Abuse (other than above)

Vocational Problems

Other: _____

Do you have a relationship with Christ? ___ Yes ___ No
Have you been baptized? ___ Yes ___ No Date: (approximately) _____
Are you regularly participating in Small Group? ___ Yes ___ No
Are you tithing to Faith Promise? ___ Yes ___ No
Are you serving at Faith Promise? ___ Yes ___ No
What ministry area? _____

In a typical week how often do you:
Exercise: _____ Use recreational drugs, specify: _____
Drink Alcohol: _____ Use prescription drugs, specify: _____
Use caffeine: _____
Smoke cigarettes: _____

Are you in recovery? Yes No Details: _____
Primary Care Provider: _____ Phone: _____
Address: _____
Name, address and phone number of an emergency contact *not living with you*: _____

Describe your family growing up? _____
Describe your family now? _____
List family members who have had substance abuse history: _____
List family members who have had history of mental illness: _____
List loved ones who have attempted or committed suicide? _____
Do you have one or more close friends? Yes No
How would you describe your spiritual development or faith at this time? _____

By signing below, I acknowledge that I have read and fully understand the terms and policies of the Faith Promise Church Counseling Ministry and will abide by them.

I also understand that conversations are confidential except in the following situations:

- child or elder abuse, protecting those at risk of harm to self or others, court order or subpoena, or complying with the Patriot Act (threat to national security).

I also understand:

- I may be seen by a counselor-in-training, and be asked to audio-record sessions for the purpose of supervision only.
- Counselors cannot guarantee specific outcomes and reserve the right to consult with each other to provide the highest quality of care
- If I no show or cancel 2 consecutive appointments, my time slot will be offered to another client.

Signature Print Name Date

Consent to treatment of minors (only necessary for parents of minors).

This section must be completed by the parent or legal guardian of each child. In divorce situations, custody agreements often require the signature of both parents for counseling or medical treatment. While counselors respect confidentiality in counseling, parents will be encouraged to be part of the process. If the counselor becomes aware the minor child is making dangerous or poor decisions, the parents will be brought in the conversation as soon as possible. In situations involving suicidal ideation or attempts, parents or guardians will be contacted immediately.

Name of Minor _____ Birth date _____

Parent/Guardian (print) Parent/Guardian signature Date

Parent/Guardian (print) Parent/Guardian signature Date