MCCC Intake Form

Name_____ Date_____

Marital Status_____ Age_____ Birthdate _____

Sex_____ Racial/Cultural affiliation_____ Preferred Pronouns _____

Anyone in session with you will need to complete separate paperwork.

Address_____

City_____ State_____Zip_____

Phone_____ Do you mind if center leaves a message? __Yes/No_____

Do you mind if the center texts 'remind" appointment reminders? __Yes/No_____

Email _____

Initial preferred ways to be contacted: ____ call ____ text ____ email

Do you have children? ___Yes/No_ Ages:_____

Names_____

_____

Occupation and place of Employment_____

Education: _____Post Graduate _____College _____Prof. Certification _____Highschool

The Counseling Process

Payment process: Our services are $110. We do have reduction rate through scholarships for those who qualify and apply through the reduction form. Then the rate is $60. We do not take Insurance.

Confidentiality: 1/we understand that counseling services are confidential. Some of the major conditions under which the counselor is obligated NOT to maintain confidentiality are: danger to self or others, abuse of children/dependent adults. I/we also understand that in couple, parent-child, or family therapy, secrets about important information may interfere with counseling, and the counselor may encourage me/us to share critical information with those who should know. I/we also understand that in certain instances, it may be difficult to continue counseling if I/we choose not to reveal important information that would aide in the therapeutic work of counseling.

Consent to Treatment: I am/we are entering into this counseling contract with full understanding, participation, and consent. I/we understand I/we have a right to a second opinion from another mental health professional.

Disclosure of Information: In a commonsense circumstance, a counselor will make every effort to ensure that those who may '*need to know*' will strive to maintain confidentiality with permission to disclose only what is needed to other professional or involved parties for the good of the client (s) and with transparency of permission. Such circumstances include: Being evaluated for a disability by a third-party professional, a formal request for information from another therapist, physician, case manager, ect. In the event that primary counselor is (unavailable, and/or has died) then your records are shared with another counselor to review your needs, and plans of care to be attended to by another staff counselor/therapist. Authorize the collaboration of inter-discipline professionals to address your case for a higher standard of plan of care for treatment.

Client 1:_____Date: _____

Client 2:_____Date:_____

Counseling History

Have you been in counseling before? Yes/No Where_____ How long ago? _____

If referred to counseling, please check the source that told you about the MCCC:

- Church, friend, neighbor_____
- Chamber of Commerce or Civic organization_____
- Court Referral_____
- Employee Assistance Program from work_____
- Website/Google_____
- Other_____

State the reason for your visit today._____

_____

_____

_____

_____

Please list any medical conditions including past diagnoses._____

_____

Please list current medications._____

_____

Have you taken medication in the past for depression, anxiety, or other diagnoses in the past?
If yes please list._____

Please list current physician and address._____

Milledgeville Christian Counseling Center

Please answer yes or no to the following questions.

1. Do you have difficulty sleeping? _____
2. Have you or others been concerned about your alcohol or drug use?_____
3. Do you have any memory issues?_____
4. Are your thoughts confused/disorganized?_____
5. Are there any challenges and/or difficulties in inter-personal relationships

Such as spouse, parent, sibling, or other:_____

6. Are there any concerns with social skills?_____
7. Do you struggle with tiredness, low energy, lethargy_____
8. Are you depressed?_____
9. Are you anxious/fearful/ phobias?_____
10. Are you angry?_____
11. Are there pressures with financial, social, or spiritual concerns?_____
12. Do you starve yourself or make yourself throw up?_____
13. Do you have sexual concerns?_____
14. Do you have legal concerns?_____
15. Do you currently have thoughts of hurting yourself?_____
16. Have you ever had thoughts of hurting yourself?_____How long ago?_____
17. Do you currently have thoughts of hurting others?_____
18. Do you currently have a stable living situation?_____
19. Do you have current legal issues?_____
20. Do you have a local support system?_____

Comments on anything else you wish for us to know:

_____

_____

_____

_____

_____

Client Signature or Signature of Person completing intake packet

_____

Date

Milledgeville Christian Counseling Center

Spiritual Assessment

Please answer yes, no or with a short answer.

1. Is Religion or Spirituality an important part of your life?_____
2. Do you consider yourself a part of a religious group?_____
3. If so, Please name_____
4. Do you participate in a supportive religious/spiritual community?_____
5. How often do you participate? (ex: once a week, monthly) _____
6. Do you engage in spiritual practices? (ex: prayer, reading, meditation)_____
7. How often? (ex: daily, weekly) _____
8. What spiritual practices do you find most helpful?_____
9. Do your spiritual practices aide you in a relationship with God?_____
10. If yes, how do the practices aide in your coping?_____

    _____
11. Has your current situation effected your spirituality?_____
12. Who has most influenced your spiritual life? _____
13. Do have trouble with forgiveness, hope, or regret?_____
14. Do you struggle with emotions?_____
15. Would you like your spirituality to be a part of the therapeutic conversation?_____

_____

Client Signature or Signature of Person completing intake packet

_____

Date

Adapted from "The Hope Approach to Spiritual Assessment" by G. Anandarajah & Hight

Http://Loriheifner.com/SpiritualAssessmentTools2.pdf?

Milledgeville Christian Counseling Center

Policies/Consent to Treatment (Continued)

Continued/ MCCC Policies for Children (if applicable please fill out fully for your child/children) If not a part of the intake need please check _____N/A

For safety reasons we ask that you not leave a child under thirteen years old in the waiting area unsupervised. If at all possible, we ask that you not bring children who are not a part of the therapy to a session unless requested by your therapist. Children under 18 must have permission from both parents to be seen by a therapist. This means the signatures of both parents are required on this form. Specific circumstances may be addressed with the director or your therapist.

Information on minor to treat:

Name of child:_____

DOB:_____ Height:_____ Weight_____ Gender_____

Grade in School:_____School attending:_____

Any special programs in school:_____

Teachers/ Principals/Counselors aware of child's needs:_____

_____

_____

Does child have special hobbies, sports, music, art or any specific interests?_____

_____

_____

_____

Tells us about other activities such as church/faith community, friends, groups they are a part of:

_____

_____

Family History: Tell us what we need to know to serve minor child regarding parents, stepparents, grandparents, sibling, and significant other relatives or relationships that may have impact on child's emotional, mental, and physical support. _____

_____

_____

_____

_____

Any other comments needed to share (School concerns, health matters, behavioral issues)

_____

_____

_____

_____

_____

Please sign below signifying that you have read and understand the policies written and consent to treatment.

_____

Client Signature

Parent or Guardian for minor

_____

MCCC Representative

_____Date_____

MCCC Acknowledgement of Understanding
Regarding the 24-Hour Cancellation and "No Show" Fee Policy

Please initial below that you have read and understand the MCCC 24-Hour Cancellation and "No Show" fee policies found in the Center Policies/ and Consent to Treatment. I understand if I am late to an appointment the therapist cannot "make-up" that time.

_____ Client Initials