CROSSROADS CHRISTIAN COUNSELING CENTER

PHONE:812.518.1490
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CCCGO.COM/COUNSELINGCENTER

SIGNATURES – ADULT COUPLES

Client Full Name_____ DOB:_____
Client Full Name_____ DOB:_____

MISSED APPOINTMENTS

I am financially responsible for my attendance at all scheduled appointments, unless cancelled at least 24 hours in advance. **I agree if I do not cancel to pay $30 for each missed appointment**. Excessive misses may result in termination of counseling or payment of the full fee for missed sessions.

ACCOUNT RESPONSIBILITY

I agree to make payment for all services rendered at the time of my appointment. I understand that if I suspend or terminate my treatment that all outstanding balances are due and payable. I understand that I will be charged based upon the amount of time I am with my counselor. I agree to the fees listed in the Policy statement. I agree that any additional time (consultations, reports, letters, email, etc.) will be prorated and charged to me at the normal rate. CCC also reserves the right to forward your information to a collection service if there is a default on any payment obligations described in this agreement.

COURT AND LEGAL ACTION

Because of the adverse impact on the counseling relationship, I agree that should there be any legal proceedings (such as, but not limited to, divorce, custody, injuries, lawsuits, etc.) that **neither I nor my attorney (or anyone acting on my behalf) will call on my therapist to testify in court or any other proceeding**. Additionally, I agree that **I will not direct the subpoena or request of psychotherapy records** for any potentially adversarial reason.

PRIVACY PRACTICES

I am attesting that **I have received, understand and agree to the Counseling Policies** of CCC including the notice of Privacy Practices. I understand that CCC cannot guarantee that correspondence via fax, email, text or cellular service is completely confidential. If I use or agree to these means of communication, I accept the limitations.

CONSENT FOR TREATMENT

I do hereby seek and consent to take part in my treatment with a counselor of Crossroads Counseling Center.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this counselor.

I am aware that I may stop my treatment with this counselor at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, therapy that has been court-ordered).

MY SIGNATURE INDICATES THAT I HAVE BEEN PROVIDED A COPY OF, AND THAT I UNDERSTAND AND AGREE TO ALL THE TERMS AND CONDITIONS OF THE COUNSELING POLICIES.

Signature of Client_____ Date_____

Signature of Client_____ Date_____

Signature of Counselor_____ Date_____

CROSSROADS CHRISTIAN COUNSELING CENTER

This document must be filled out separately by each person

Name: _____ (circle) Male Female

Date of 1st appt: _____ Birthdate: _____ Age: _____

Address: _____ City/State/Zip: _____

Primary Contact Phone: _____ Permit use of text? Yes No

Email (please print clearly)_____ Permit use of email? Yes No

Who referred you to us? _____

PLEASE NOTE: **If you would prefer to answer some of these questions verbally with your counselor just note that in the relevant section.**

FAMILY INFORMATION

Name of Spouse/Significant Other: _____ Spouse Phone: _____

Emergency Contact (if different from above): _____ Phone: _____

Status: ☐ Married ☐ Living Together ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Names of Children	Age	Gender	Living where/custody

Significant others potentially relevant to counseling (e.g., grandparents, step-relatives, etc.)

Name	Relationship

EMPLOYMENT

Recent or current employer: _____

Type of work (e.g., sales, IT, manager, skilled labor, etc.): _____

Is work apart of why your seeking counseling? ☐ Yes ☐ No If yes, please explain:

PRIMARY REASON(S) FOR SEEKING SERVICES (CIRCLE)

Anger management	Excessive Worry	Coping/Life transitions	Depression
Eating Issues	Anxiety/Fear	Relationships	Social Concerns
Sexual Concerns	Assessment	Trauma	Work/Career
Grief/Loss	Spirituality	Self-Esteem	Parenting

Other:

DESCRIPTION OF PRESENT DIFFICULTIES:

Please briefly describe the problem(s) that you want to talk about in counseling

Please note any significant events (not mentioned previously) related to the development or continuation of your problems:

Have you been in treatment before? ☐ Yes ☐ No Name of counselor and treatment dates :

Would it be helpful for us to contact her or him? ☐ Yes ☐ No

What was helpful and/or were there any problems with the treatment or therapist?

Have you ever been diagnosed with a psychological disorder? Please describe:

Have you ever been hospitalized for a psychological/psychiatric reason? If so, please describe and list the dates.

Please describe other people and/or relationships (not mentioned previously) that are a factor in your present difficulties: (Ex., siblings, grandparents, in-laws, etc.)

What are your goals for therapy?

Are there any symptoms that impair your ability to function effectively?

MEDICAL HISTORY:

Primary Physician and/or Group:

Date/estimate last visit: Aware of your therapy? ☐ Yes ☐ No

Psychiatrist (if any):

Dat/estimate last visit: Aware of your therapy? ☐ Yes ☐ No

Please list any relevant medications and dosage you are taking or have taken within the last 6 months

Name	**Dosage (amount & frequency, ex. 25mg 1x day)**	**MD prescribing**

Do you exercise regularly: ☐ Yes ☐ No If so, what type and how often?

Please describe your average or typical sleep pattern:

How much sleep do you get each night on the average?

Any problems with falling asleep?

Do you have a hard time waking up?

Too much or too little sleep?

Other issues, problems or treatment (ex. CPAP)?

Please explain any recent or unusual physical symptoms:

Are there any other physical problems/illnesses that may be relevant to counseling?

Please check if you, your partner or other family member (if relevant) uses any of these excessively/abusively in your opinion (add + if you think major problem):

Self/Partner/Family	Self/Partner/Family	Self/Partner/Family
Caffeine	Tobacco	Alcohol
Marijuana	Narcotics	Amphetamines
Cocaine	Hallucinogens	Pain Killers
Other	Please describe	

Please explain how this impacts you and/or your relationship(s)

ACADEMIC/MILITARY BACKGROUND

Highest level attained: ☐ Grade School ☐ High School ☐ Trad/Specialty School ☐ College ☐ Graduate School

Did you serve in the Military? ☐ Yes ☐ No

Please give some detail if relevant to treatment (ex., rank, years of service, experience, academic focus):

RELIGIOUS BELIEFS:

If you think your religious beliefs could be a factor in either the problem or helping with your counseling could you give us a brief explanation?

Is there anything else your counselor should know that would assist in your treatment?