



AGREEMENT FOR PARTICIPATION

We would like to welcome you to our office. We exist as God’s hand reaching out to the broken and hurting by providing, at no cost, emotional, and spiritual assistance. Our counseling services have NO cost to the recipient at any time.

- A full counseling session typically lasts 50-55 minutes.
- Counseling can be provided at our main office, client’s school or area churches.
- To serve the better interests of all clients, some cases may require a referral.
- Referrals are subject to fees.
- Participation is voluntary.
- Services to be received: Biblically-based counseling, consulting, and intervention.

CONSENT FOR PARTICIPATION

I hereby authorize Beacon of Hope Ministries to provide the following services: outpatient counseling that will include spiritual interventions introduced in a time and manner that will most benefit the client. These practices may include prayer for and with the clients, Bible reading and reference, the use of Biblical imagery, and assistance with spiritual formation and discipline.

CONFIDENTIALITY

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize the release of information, or under certain conditions outlined in the following:

- Where harmful neglect or abuse of children or others is suspected.
- Where imminent danger to the client or community is known.

I understand the above polices and agree to their terms.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## BEACON OF HOPE NEW PATIENT INFORMATION

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

### Presenting Problems: (Check all that apply)

	None	Mild	Moderate	Severe
Tired or Fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension or Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arguing with Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration/Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse or Related Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marital Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Drug Use Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irrational Fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Related Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessions or Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What would you like to accomplish in your counseling?

## CLIENT INTAKE INFORMATION

### Personal Information:

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Employer: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Religious Affiliation (optional): \_\_\_\_\_ Referred by: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Mental Health History: None

Have you received counseling in the past?  Yes  No

If so, when, with whom and for what reason?

Have you been hospitalized for mental health issues?  Yes  No

If so when and for what reason?

Is there a family history of mental health problems or nervous problems?  Yes  No

Please explain.

### Medical History:

Who is your Primary Care Physician? \_\_\_\_\_ Date of last visit \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

Describe any present or past health concerns/problems including childhood traumas or surgeries.

List all medications & supplements you are currently taking and dosages.

Recent weight gain or loss? \_\_\_\_\_ lbs Appetite \_\_\_\_\_

**Addictions/Substance Use/Abuse History:** (Check all that apply)

	None	Past	Present	Frequency/Amount
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever received treatment for any of the above substance?  Yes  No  
 If so, when for what substance and for how long?

Do you have any family members with substance abuse problems?  Yes  No  
 If so, list relationship and substance abused

**Family/Social History**

Parents marital status:  Married  Separated  Divorced (# of times: \_\_\_\_\_)  
 Describe your relationship with your father and mother.

Siblings names:	Age:	Marital Status	Occupation
_____	M / F _____	M / S / D	_____
_____	M / F _____	M / S / D	_____
_____	M / F _____	M / S / D	_____
_____	M / F _____	M / S / D	_____

Describe your relationship with your siblings.

Describe your adolescent years. (Attitude, feelings, likes, dislikes, etc...)

Is there any history of verbal, physical, emotional or sexual abuse?  Yes  No  
If yes, please describe.

Describe your current family relationships and living arrangements.

List and describe your support system of family and friends.

**Marital History:**

Single  Married (# of years: \_\_\_\_\_)  Separated (Date: \_\_\_\_\_)  Divorced (Date: \_\_\_\_\_)

How many times have you been married? \_\_\_\_\_  
What was your age? \_\_\_\_\_ The age of your partner(s)? \_\_\_\_\_  
If divorced, please give reason.

If married, describe the quality/satisfaction of your present marriage.

How many children do you have? Natural \_\_\_\_\_ Adopted \_\_\_\_\_ Step children \_\_\_\_\_  
Child's Name                      Age                      Marriage Status                      City/Status

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How would you describe your relationship with your children?

## **Educational/Vocational/Employment History**

How long have you been at your current job? \_\_\_\_\_ Number of jobs in the last 5 years \_\_\_\_\_

What career/educational plans do you have?

## **Legal History:**

Number of arrests: \_\_\_\_\_ Number of substance-related arrests: \_\_\_\_\_

Number of OUIL, DUIL, or DWI arrests \_\_\_\_\_

Nature of other arrests:

Other legal concerns:

## **Religious/Spiritual Background**

List any formal religious affiliation.

Please describe your involvement.