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 sessions have NO cost to the recipient at any time.

- A full counseling session typically lasts 50-55 minutes.
- 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.

COUNSELING GOALS

Beacon of Hope believes in working in cooperation to develop a clear picture of the goals you want to achieve in counseling. We are committed to honoring your time by having a plan for counseling. We will review this plan with you on a monthly basis. Our hope is that upon conclusion of counseling services, you are able to carry what you have experienced and learned in counseling on towards a better future.

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	☐	☐	☐	☐
Tension or Anxiety	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Arguing with Significant Other	☐	☐	☐	☐
Feeling of Guilt	☐	☐	☐	☐
Concentration/Attention Problems	☐	☐	☐	☐
Abuse or Related Problems	☐	☐	☐	☐
Marital Problems	☐	☐	☐	☐
Problems with Children	☐	☐	☐	☐
Sexual Concerns	☐	☐	☐	☐
Alcohol or Drug Use Problems	☐	☐	☐	☐
Physical Complaints	☐	☐	☐	☐
Memory Problems	☐	☐	☐	☐
Irrational Fears	☐	☐	☐	☐
Work Related Problems	☐	☐	☐	☐
Eating Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anger	☐	☐	☐	☐
Obsessions or Compulsions	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐
Other: ________________	☐	☐	☐	☐

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	☐	☐	☐	__________________
Drugs	☐	☐	☐	__________________
Nicotine	☐	☐	☐	__________________
Caffeine	☐	☐	☐	__________________

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

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.