LifeWay Counseling Center

Client Information Form

Date: ____________

Client Name:______________________________ Home Phone: ________________

Address: ________________________ City: ____________ State: ____ Zip: ______

Date of Birth: _____/_____/_____ Ethnicity/Race:__________________________

Gender: M__ or F__ Client Age: _________ School Grade (if applicable):______

Adult Client/Parent Information Below:

Parent/Guardian's Name (if client is less than 18 years of age): ____________________

Spouse's Name (if married): ____

Marital Status:	**How Long?**
1. ____ Single	______ Years ______ Months
2. ____ Engaged	______ Years ______ Months
3. ____ Cohabiting	______ Years ______ Months
4. ____ Married	______ Years ______ Months
5. ____ Separated	______ Years ______ Months
6. ____ Divorced	______ Years ______ Months
7. ____ Remarried	______ Years ______ Months
8. ____ Widowed	______ Years ______ Months

Employment Status:

1. Employed full-time
2. Employed part-time
3. Unemployed
4. Full-time homemaker
5. Retired
6. Full-time student
7. Part-time student
8. Other ______________________

Place of Employment: ______________________ Occupation: __________________

Work Number: _____________ Cell Phone Number: ________________________

May we leave a "call back" message **at your home**? Y__ N__ **At your work**? Y__ N__

May we contact you via mail at the home/work address given above? Y__ N__

If you would like to be contacted by email instead please provide your email address:

____

In case of emergency, please notify (include address & phone number):

____

Please List All Household Members

Name:	Age:	D.O.B.	Relationship:
____________	________	____/____/____	____________
____________	________	____/____/____	____________
____________	________	____/____/____	____________
____________	________	____/____/____	____________
____________	________	____/____/____	____________
____________	________	____/____/____	____________

Medical History

Currently under Doctor's care: Yes __ No __

Doctors involved in your care/child's care (use reverse side if necessary): ____________

____

Health Problems (include allergies): ____

Medication currently used: NONE ___

Medication	Dosage	Prescribing Doctor	Reason prescribed
__________	________	____________	______________
__________	________	____________	______________
__________	________	____________	______________

Past Hospitalizations:

Date(s)	Reason(s)	Hospital
__________	______________	______________
__________	______________	______________
__________	______________	______________

Previous Counseling, Psychiatric Services or Chemical Dependency Services

Counselor/Facility Name	Date(s)	Reason(s)	Helpful?
____________	________	____________	________
____________	________	____________	________
____________	________	____________	________
____________	________	____________	________

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What is the highest level of education you (*the primary client or parent if client is younger than 18 years of age*) have completed?

(circle number)

1. No formal education
2. Some grade school
3. Completed grade school
4. Some high school
5. Completed high school (Diploma or G.E.D.)
6. Some college
7. Completed college
8. Some graduate work
9. A Master's degree
10. A Doctorate degree
11. Other Professional degree (J.D., M.D.)

What concerns bring you to counseling?

What changes do you want to see as a result of counseling?

Please circle ALL of the following items that are currently a concern to you regarding ***YOU AND/OR YOUR PRESENT RELATIONSHIP***.

1. Premarital Counseling
2. Marital relationship
3. Remarried relationship
4. Poor communication
5. Sexual difficulties
6. Parenting concerns
7. Anxiety
8. Depression
9. Family relationships
10. Excessive alcohol/drug use
11. Stress
12. Self-esteem
13. Physical problem
14. Suicidal thoughts
15. Suicide Attempt
16. Incest
17. Childhood Emotional abuse
18. Childhood Physical abuse
19. Childhood Sexual abuse
20. Financial concerns
21. Anger
22. Grief/Loss
23. Work related concerns
24. Illness
25. Physical Abuse/Violence
26. Verbal Abuse/Violence
27. Eating Disorder
28. Cutting/Self-Mutilating Behaviors
29. Rape
30. Divorce Contemplation/Recovery
31. Other (please describe) ____

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Please circle ALL of the following items that are currently a concern to you regarding
YOUR CHILD OR CHILDREN (IF APPLICABLE).

____ NOT APPLICABLE

1. Stealing
2. Poor communication
3. Physical violence
4. Fire setting
5. Truancy
6. Drugs/alcohol
7. Adolescent pregnancy
8. Sexual **abuser**
9. Sexual abuse victim
10. Physical abuse victim
11. Divorce adjustment
12. Death/loss/grief
13. Anger
14. High anxiety
15. Peer relationships
16. Poor self-esteem
17. Bedwetting/soiling
18. Destructiveness
19. Issues with stepchildren/step-parenting
20. Disobedience
21. ADD/ADHD concerns
22. Depression
23. Eating Disorder
24. Cutting/Self-Mutilating Behaviors
25. Suicide Attempt
26. Other (please describe) ____

Please use the section below to list / describe the various strengths / positive attributes you, your spouse, your child, etc. possess:

____

____

____

____

____

____

____

____

How did you hear about LifeWay Counseling Center?

_____ Advertisement in Yellow Pages
_____ Brochure
_____ Church
_____ Doctor
_____ Friend
_____ Attorney
_____ Other ________________________

May we send the person who referred you a "Thank You" for the referral?
If yes, please provide the referring person's name and address below:

____

____

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Policies and Procedures

About Our Fees

- Usual and customary fees are $100.00 for an individual, 50-minute counseling session. ***Should a session last more than the usual 50-minutes, fees will be adjusted accordingly***. Phone consultations that last longer than 15 minutes are subject to half the usual and customary fee. *At the present time, LifeWay Counseling Center accepts Blue Cross/Blue Shield and Cigna. Each client will be notified in writing should this change in the future.* A sliding scale fee is available for intern appointments and is negotiated based on a formula derived from household income and number of dependents.
- Usual and customary fees are between $700.00 and $900.00 for a psychological evaluation (battery of assessments) whether ordered by the court system or requested from an individual. Cost is based on what is required in the battery. We do not accept insurance for any court ordered psychological evaluation.
- Court testimony costs begin at $175.00 an hour with a $600.00 retainer due prior to the court date. Travel is billed at .45/mile.

Payment is to be made at the conclusion of each session and all checks need to be made payable to: ***LCC***. ***Please note that there will be a $25.00 fee assessed for any returned check.***

I understand that my fee will be $______for each counseling session. Please initial ______

Client Commitment to LifeWay Counseling Center

LCC is committed to providing you with affordable and professional counseling services. To assist us with our efforts, we ask that you read and sign the following agreement:

I, ________________ will make every effort to come for each counseling appointment. If it is necessary to cancel an appointment, I understand that this should be done at ***least 8 hours in advance***. *Should I fail to notify the counselor and miss an appointment, I understand that the usual fee will be assessed and that it will be my responsibility to pay for the missed session. Further, should I need to reschedule an appointment, I understand that fees will be assessed based on the following schedule:*

8 hour notice (or more) = *no charge*
Less than 8 hour notice = *35% of normal fee*
Less than 4 hour notice = *65% of normal fee*
Failing to show for appointment without notification = *full fee*

X____ ________________

Signature of client or parent/guardian *Date*

Statement of Confidentiality

A. **Confidentiality:** Under Texas law, a counselor cannot guarantee confidentiality under the following circumstances:

1. There is suspected or witnessed child abuse or a belief that a child may be in imminent danger of abuse/maltreatment
2. There is suspected or witnessed elder abuse or a belief that an elderly person

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may be in imminent danger of abuse/maltreatment
3. There is suspected or witness abuse of a disabled person or a belief that a disabled person may be in danger of abuse/maltreatment
4. There is a threat of suicide / homicide, in which case the counselor may contact the appropriate authorities who can help prevent harm
5. In response to a properly issued subpoena from the court or order from a presiding judge.
6. There is a request from the State Licensing Agency for the client's records. In this event, those records shall be made available for the purpose of insuring professionalism.

B. **Except as noted in A above,** no information regarding a client shall be released without the prior written consent of the client or in the case of a minor, the written consent of the minor's parent/legal guardian.

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:

TX State Board of Examiners of Professional Counselors OR TX State Board of Examiners of Marriage & Family Therapists
Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369

I have read & understand the limits to confidentiality ________________ (initial here)

Disclosure Statement & Consent for Treatment

Please be aware that the therapeutic process may involve personal awareness that may be emotionally painful, may cause heightened emotions, may cause anxiety, tension or stress and may cause some disruption or turmoil in your life as well as the lives of your significant others due to the subject matter being disclosed.

Counseling/therapy also has the potential to provide emotional support and stability for any family member involved in therapy. Further, it may relieve anxiety and create a safe environment for children or family members who are distressed. Finally, counseling/therapy has the potential for creating positive life changes in the form of long-term solutions to difficulties, and creating better communication.

I have read and understand all the above statements (**session fees**, **client commitment**, **limits to confidentiality** & **the disclosure statement**) and I voluntarily consent to treatment.

Signature of self/parent/legal guardian: ____

Signature of spouse / witness: ____

Date: __________________

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Policies and Procedures
(Client Copy)

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