My Abundant Life Now Counseling Service

Pre-Intake Interview Form

Name: ____ Date: _________

Phone: _________________________ Cell/Home Best time to call: ____________

Is it ok to leave a message on your answering machine? Yes No

How did you hear about the service: ____

What happened to cause you to believe you need counselling now?

____

____

____

What is the specific issue you're seeking help for?

____

____

____

How long have you have you been dealing with this issue?

____

Is this a recurring issue? Yes No Explain: ____

____

____

What will let you know that this issue is resolved? ____

____

Have you had counseling before: Yes No By Whom? _____________________________________

What were the results?

____

____

FOR OFFICE USE ONLY:	
Location of session:	Date of session:
Time of session:	
Agreed fee:	

My Abundant Life Now Counseling Service

Welcome to My Abundant Life Now Counseling Service

Cheryl Williams is the owner and lead counselor of My Abundant Life Now Counseling Service, a Faith-Based Counseling Service. The objective is to provide professional counseling service in a secure and confidential environment. Our practice and recommendations are Biblically based, and our services are available to anyone who is amicable to this method of using Biblical principles. All counselors are certified, well equipped and empowered to encourage and guide clients toward abundant fulfilled lives.

Below are guidelines for services.

Session Details:

Regular attendance is required for best outcomes. My Abundant Life Now Counseling Service (counseling service) does not guarantee any outcome as a result of coming and participating in counseling sessions at the counseling service. The outcome of each client is different and largely depends upon the effort(s) and commitment made by the client. The first session may last up to 120 minutes thereafter each individual therapy session will last 50 minutes, couples therapy can last from 90-120 minutes. The service offered is primarily short-term counseling, which consists of 17 counseling sessions and three follow-up sessions.

Fees:

The regular fee is $80.00 per hour, however each client is given a fee consultation and their fee will be agreed upon during the intake session. There after the agreed fee will be due at the beginning of each session. Please note that phone session outside of regular scheduled visits are $35.00 per call and limited to 35 minutes. If call goes beyond 35 minutes the full agreed fee will be due and payable at the time of the session.

Arriving Late:

Please contact the counseling service at (888) 308-7590 if you will arrive late to a counseling session. If you are less than 15 minutes late, the counseling session will begin at the time you arrive and end at the usual scheduled completion time. Please be aware that if you are more than 15 minutes late without notice the session will be cancelled and there will be a fee for the regular session. You may reschedule.

Notice of Cancellations:

Due to the brevity of service provided, a 24-hour cancellation notification is required for a single missed session. Session that are canceled within one hour of the set appointment will be charged for a regular session and payment of that missed session is due at the beginning of the next session. If you are unable to attend sessions due to a pending vacation, please notify the counseling service a week in advance of the intended missed sessions. **If clients miss three sessions, with the exception of vacation time, it may be presumed that the clients are no longer interested in continuing sessions and the counseling service will be terminated.** You may request service again when you are ready to commit.

Availability:

Counselors are available for scheduled appointment times Saturday, Sunday and Monday by appointment only. In the event a counselor will not attend a session, clients will be notified in advance of the intended absence.

My signature below indicates that I understand the above and that I have received a copy of these guidelines.

Client's Name (print)	Client's Signature	Date
If minor: Parent's Name	Parent's Signature	Date

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Individual Informed Consent and Confidentiality Agreement

In accepting service from My Abundant Life Now Counseling Service (the Service), I understand that all information provided to the Service/counselor will be treated with the highest standard of confidentiality. The Service/counselor will not disclose client confidences except under the following legal conditions:

1. By the client's written request and consent
2. When mandated or permitted by law, such as in the following cases:
    a. When child abuse and/or neglect is known or suspected
    b. When elder or dependent adult abuse and/or neglect is known or suspected
    c. When a client is a danger to self or others
    d. When the court has issued a subpoena for records.

I authorize and direct the Service to perform counseling procedures as professional judgment may indicate for the well-being of myself, my child and or family. I understand that no guarantee is made as to the results of treatment. Results of treatment are mainly up to me to follow through with assignments and my wiliness to heal.

Know that any representative of the Service will not participate in a dual relationship with clients in order to protect the therapeutic process and to maintain the legal and ethical boundaries set for counselors.

Fees for services are determined in consultation with the counselor. I understand that the fee for services is payable before services are rendered. Cash is preferred however, if you need to use a check please make checks payable to Cheryl Williams and your correct phone number appears on the check. I also understand that there will be a $35.00 charge for returned checks. Credit, debit and PayPal are accepted.

I understand that I am responsible for keeping my appointments and that I am responsible to notify the Service at least 24 hours in advance of any appointment which cannot be kept. If I provide less than 1 hour notice, I will pay the full fee, which is due for this reserved time. This policy helps to make the Service time available to others.

I understand that as a client of the Service, I have the following rights:

1. The right to confidential treatment of my personal records as outlined in the Privacy of the Client Information statement above.
2. The right to have my fees for counseling adjusted when there is a change in my income or family status.
3. The right to refuse any procedure or referrals recommended or prescribed by my counselor.

I acknowledge that I have read and received a personal copy of this statement and have had questions answered in a satisfactory manner.

____________________________ ____________________________________

Print Client Name | Client Signature | Date

____________________________ ____________________________________

If minor: Parent's Name | Parent's Signature | Date

____________________________ ____________________________________

Counselors' Signature/Credentials | Date

My Abundant Life Now Counseling Service

Client Information Intake

Identifying Information

Name: ____ Today's Date: _______________

Address: ____ City: __________ State: _______ Zip: _____

Phone: ___________________________ Email: ____

Gender: ____ Age: _____ Date of Birth: _______________ Ethnicity: ____________________

Language spoken: English Spanish Other___________
Reading preferences: English Spanish Other___________

Are you currently experiencing any legal problems? Yes No
If yes, please explain: ____

____

Are you currently having any financial difficulties? Yes No

If yes, please explain:____

How did you hear about the counseling service? ____

What are your expectations from the counseling service? ____

____

Spiritual Profile

Is Jesus Christ your personal Lord and Savior? Yes No What do you expect from a faith-based counseling service?
____
____
____

Have you been hurt by anyone in the church? Yes No Do you read the bible? Yes No
Do you attend a weekly church service? Yes No Do you pray often? Yes No
Are you filled with the Holy Spirit with the evidence of speaking with tongues? Yes No
Are you satisfied with your relationship with God the Father, God the Son and God the Holy Spirit? Yes No

Occupational History

What is your current Occupation? ____ For how long? _____

Are you satisfied with your current occupation? Yes No Please describe your day-to-day activities: (If you are unemployed or retired state your daily activities): ____
____
____

Circle any current on-the-job issues:

Trouble with boss	Frequent tardiness	Separation/Discharge	Conflict with coworkers
Force-shaping	Memory problems	Too much responsibility	Trouble with subordinates
Single parenting	Harassment	Can't get organized	Concentration problems
Disciplinary actions	Discrimination	Trouble with customers	Fatigue
Shift work/scheduling	Retirement	No promotion	Other:

Explain any on-the-job issues or daily activities that may contribute to you seeking counseling:
____
____

How well do you think you are keeping up with your responsibilities on the job and at home? (circle choice)
Very poorly Poorly Fair Well Very well

Relationship History

Marital Status: S M Sep D W How long ________

Spouse's Name: ____ Age: _____ Date of Birth: _________

Have you been married more than once? Yes No How many times? ____

If you are single, are you in a serious romantic relationship? Yes No

In your relationship (married or otherwise) how would you rate your overall satisfaction with the relationship? (Circle which describes you best): 1 = Very dissatisfied 2 = Dissatisfied 3 = Neutral
4 = Satisfied 5 = Very Satisfied

What problems, if any, do you have in your relationship? ____
____
____

What strengths do you have in your relationship? ____
____

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Personal and Social History

Do you have any children? Yes No If so how many? ____

Name	Age	Male / Female	Living with you?

Were you adopted? YES NO Number of siblings: ___________

Your number in birth order (please circle) 1st 2nd 3rd 4th 5th 6th 7th 8th 9th

Do you have a good relationship with you siblings? Yes No

Where were you born? ________________________ Where you raised there? Yes No

If not where? ________________

Where your parents divorced? YES NO If so, when? _______________

If your parents divorced how old were you when it happened? ____________

How did the divorce affect you? ____

If your parents are divorced, with whom did you live? ___________

Where you close to your custodial parent? Yes No

Where you close to your non-custodial parent? Yes No

How is your relationship today? ____

Custodial: good or different Non-custodial: good or different

How much time did you spend with your non-custodial parent? ____

If none, why not? ____

Educational History:

What is the highest grade level of education you completed? ____________

Did you attend College/University: Yes No

Did you earn a degree? (circle your degree (s)): BA BS MA MS PhD In what discipline? _________________

Was there any history of a learning disability or special educational need? Yes No

Was there a subject in school which gave you particular problems? Yes No

If so, what? ____

Please describe any behavioral problems during school as a child and as an adolescent (e.g. skipping classes, fighting, smoking, etc.). ____

____

____

If you are a child or adolescent please answer the following questions:

What school do you attend? ____

Do you get along with your classmates? Yes ___ No ___ If "No" why not? __________________________________

____

Do you get along with your teachers? Yes ___ No ___ If "No" why not? ______________________________________

____

Do you get along with your parents? Yes ____ No ____ If "No" why not? _____________________________________

____

Main Concern (Presenting Problem)

Please describe the primary problem/concern for which you have come to counseling. _______________
____
____
When did the problem/concern begin? ____
How often do you experience the problem/concern? ____
What event led to your decision to seek help at this time? _______________________________________
____

Please circle the description that best estimates the overall impact your problem(s) has (have) on you:
Mildly upsetting Moderately upsetting Severe Very severe Extremely severe

What has been the impact of the problem on your daily routine, your life, and /or others? ______________
____
____

What solutions to the problems have been most helpful? ____
____
____

Background Information:

Have you had previous experience with counseling? Yes ___ No ____ Where? ________________

How Long? ___________

What is your level of motivation to complete counseling? High ____ Medium_____ Low _____
Don't Know _____

Please draw a picture or write a paragraph of how you feel right now:

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Background Information Continued

Describe your living environment: (who do you live with? Is it peaceful or stressful? Is it healthy? Is it hostile?)
____
____

Are there any multicultural issues that contribute to your problem? Yes ____ No _____

Can you explain them? ____
____

Behaviors (Circle any of the following behaviors that apply to you recently within the last 14 days):

Gambling	Can't keep a job	Loss of control	Difficulty controlling sexual behavior
Spending sprees	Take too many risks	Decreased interest	Others: ______________________
Vomiting	Uncontrolled alcohol use	Excess hand washing	______________________
Crying	Procrastinate	Sleep problems (excess)	______________________
Aggressive	Temper outbursts	Avoid places/activities	______________________
Impulsive	Decreased energy	Social withdrawal	______________________
Smoke more	Odd behavior	Concentration problems	______________________
Flashbacks	Nightmares	Work too hard	______________________
Eating problems	Fears	Viewing pornography	

Circle any of the following that applied to you during your childhood and adolescence:

Happy childhood	Physical abuse or neglect	Drug or alcohol abuse
Legal troubles	Death of parent	Emotional/verbal abuse
Medical problems	Emotional problems	Poverty
Parents divorced	Family problems	Sleep problems
Unhappy childhood	Bed wetting	Language or speech problems
Run away from home	Cruelty to animals	Other: ________________
Fire setting	Sexual abuse	________________
School problems	Behavioral problems	________________

Circle any of the following that apply to you during your adulthood:

Legal troubles	Physical abuse	Victim of violence
Medical Problems	Emotional problems	Drug or alcohol abuse
Perpetrator of violence	Poverty	Sexual abuse

Substance Use/Abuse History:

Are you using any drugs now? Yes _____ No _____ Have you used drugs in the past? Yes _____ No ______

If yes, what did you use? ____ For how long? _____________

Have you used alcohol? Yes ____ No ____ If yes, how often? ______Do you drink often? ____ Drink alone? ____

Have you passed out from drinking? ________________

Do you self-mutilate? (self-cut) Yes ___ No ___ Have you ever? Yes ___ No ___ If "Yes" when was the last time? ____________

Nutrition

Have you recently lost weight? Yes No Have you recently gained weight? Yes No if so, how much: ____

Have you received any treatment for eating problems? Yes No

If so, when? ______________________________ Where? ____________________________________

Medical History

Are you seeing a physician currently? Yes No If "Yes" please give the name and location of your physician: _________________
____
If "No", when was the last time you had a physical? ____
Please list any current or past developmental or educational challenges. ____
____
Please list any allergies (food or medication): ____
Please list any mental health/substance abuse issues in your family (parents/siblings/grandparents):
____
Have any medications been prescribed to you in the last 6 months? Yes _____ N0 _____

Physical (Circle any of the following that you find troublesome and/or apply to you recently)

stomach trouble Chest pain Bowel problems Sexual problems Tics Fatigue Short of breath	Hear things Rapid heartbeat Skin problems Unable to relax Tremors High blood pressure	Sweating Dizziness Muscle spasms Twitches Palpitations Visual problems	Headaches Numbness Dry mouth Fainting Tension Blackouts Problems Others _______________ _______________ _______________	For Office Use Only: ______________________________ (×17)

Counselor's Notes:
____
____
____
____
____
____
____
____
____
____
____
____
____
____

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Emotional Background Information

Circle any of the following emotions that you find troublesome and/or apply to you in the past 4 weeks

Angry Envious Hopeful Lonely Frustrated	Sad Guilty Helpless Anxious Confused	Excited Relaxed Contented Happy Suspicious	Jealous Fearful Conflicted Bored Distrustful	Panicky Tense Energetic Restless Other: ____________	Counselor's Notes: ______________________________ ______________________________ ______________________________ ______________________________

Have you ever thought about suicide?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you recently had thoughts of harming yourself?	Yes	No
Have you ever thought about hurting someone else?	Yes	No
Have you ever hurt someone else?	Yes	No
Have you ever been a victim of domestic violence?	Yes	No
Are you currently in an abusive relationship (physical, emotional)?	Yes	No

Please describe "yes" responses: ____
____
____

Pain

If you are in pain complete the following:
Circle the number on the scale below that best describes the amount of pain you are presently experiencing:

1	2	3	4	5	6	7	8	9	10
Slight				Moderate					Extreme

Is the pain (check one) ____ constant, or ____ comes and goes? Where does the pain occur? ____________

What causes the pain? ____
Are you currently being treated for pain? Yes No

Personal Strength

Please tell us about some of the healthy areas of your life. Add anything positive about you. What you include does not have to apply to you all the time to be mentioned. It's okay to brag about yourself!

Your leisure time activities	**Your better skills**
Future goals	**Family**
Health habits	**A past accomplishment**
Other good stuff?	

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GOALS FOR TREATMENT			
In seeking help, I would like to concentrate on…(Circle all that apply) Write the numbers of the 3 most important goals listed below by number of importance: _____________, _____________, ____________			
1. Feeling less depressed	10. Learning how to relax	19. Improving my sleep	28. Improve work relationship
2. Feeling less anxious/fearful	11. Feeling less angry	20. Dealing with loss/death	29. Managing my temper
3. Doubting myself less	12. Thinking more positively	21. Improving marital relationships	30. Receiving medication help
4. Not reacting so emotionally	13. Having more fun	22. Controlling my eating or weight	31. Learning how to improve friendships
5. Improving family relationships with ____________________	14. Reducing my sensitivity to criticism or disappointments	23. Learning how I come across to others	32. Adjusting better to a past incident
6. Learning problem-solving techniques	15. Discussing thoughts of harming self	24. Improving sexual relationship	33. Tolerating my mistakes
7. Discussing desire for separation/discharge	16. Expressing myself more assertively	25. Improving communication skills	34. Other: ________________________
8. Allowing myself to express feelings more	17. Adjusting better to a recent change	26. Controlling my use of alcohol or drugs	35. Other: ________________________
9. Talking out a pending decision	18. Discussing thoughts of harming others	27. Forgive someone	36. Other: ________________________

Counselors Notes

My Abundant Life Now Counseling Service

Thank you for the effort and time you have extended in completing this questionnaire.

We hope this effort will also help you in better defining and focusing in on the changes you want to make to better you level of functioning. Please tell us in the space below anything else you would like us to know about you or your background that would help us work with you toward your goals. ____

____

____

Emergency Contact Information		
Name	Phone Number	Relationship to you

FOR OFFICE USE ONLY:

Intake reviewed by: ____

____/____________________

Reviewer's signature Date paperwork reviewed