CROSSROADS COUNSELING

emphasizing biblical hope & restoration

Confidential Client Intake Forms (Parent/Child)

Dear Friend,

Welcome to Crossroads Counseling. We are grateful that you have welcomed us into your life at this time. It is never easy to ask for help. We admire the courage, faith, and humility this first step represents on your part. It is our prayer that God will bless this initial step and the steps that will follow in counseling.

Our goal at Crossroads is to provide the highest quality, Christ-centered counseling to individuals and families who are hurting and confused. This means that the counseling you receive will focus upon helping you identify how the beliefs, values, and allegiances of your heart (Prov. 4:23; Matt 6:21; Luke 6:45) express themselves in your emotions, relationships, decision making, and identity. Your counselor will help you examine how your heart has been influenced and what your heart is currently seeking. Through intelligent and guided repentance, faith, and obedience we will seek to effectively love God and love neighbor (Matt. 22:37-40) in order to experience the love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control (Gal. 5:22-23) God intends for us.

The next step in counseling for you is to complete the intake forms you are now reading. We have designed them to allow the counseling process to start smoothly. **You will need to allow approximately 45 minutes to complete these forms.**

The counseling forms are designed to **(1)** help us to get to know you in a comprehensive, wholistic, and efficient manner and **(2)** help you organize your thoughts about your counseling objectives.

- You will find both map and written directions on the next page to allow you to find the office easily.
- **The first appointment is for one or both parents/guardians only. The minor should not attend this appointment with you.** When counseling minors, establishing a relational atmosphere is essential for effective counseling. Bringing your child to this data gathering appointment inhibits your counselor's ability to initiate counseling in an effective manner.
- **The parents should complete the next seven (7) pages of this packet** – up to and including the "Consent to Counsel". As you complete these materials provide your perspective of what your child is experiencing at this time. **The final two (2) pages should be completed by the minor** and brought to the first appointment by the parent/guardian.

NOTE CONCERNING MEDICATION: If you are taking any prescription medication(s) please do not alter your dose on the day of your appointment. If have recently begun a new medication, please allow approximately two weeks before scheduling your appointment.

Office hours may vary; please contact the office for availability. Counseling sessions will require you to be in our office for approximately one hour. Please be prepared for this. Bathroom facilities are available. Childcare is not provided.

We are grateful to be able to serve you at this time and to be a part of the journey God has for you. We look forward with a sober anticipation towards playing a role in your progress and hope.

Brad Hambrick

Brad Hambrick, M.Div., Th.M.
Executive Director
Crossroads Counseling

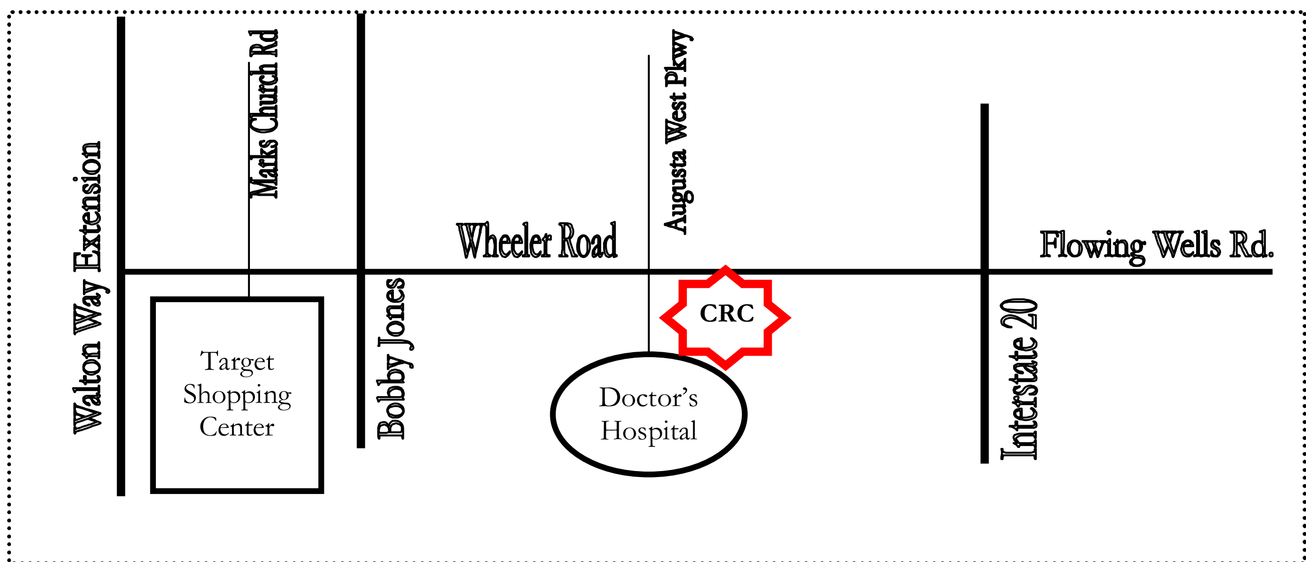
Directions to Crossroads Counseling

DIRECTIONS FROM I-20 & FLOWING WELLS RD:

At the I-20 intersection Flowing Wells becomes Wheeler Road. Drive down Wheeler Road until you come to the stop light in front of the Doctor's Hospital Complex. The hospital will be on your left and Rite Aid will be on your right. You will need to be in the far left lane and make a U-turn. DO NOT TURN INTO THE DOCTOR'S HOSPITAL COMPLEX. After making the U-turn, turn right into the **first** parking lot on your right (this will be the Boutwell Chiropractic building). On the first floor of the Boutwell building there are two office suites. Crossroads is the office on the right.

DIRECTIONS FROM BOBBY JONES & WALTON WAY EXT:

Drive down Wheeler Road until you come to the stop light in front of the Doctor's Hospital Complex. The hospital will be on your right and Rite Aid will be on your left. DO NOT TURN INTO THE DOCTOR'S HOSPITAL COMPLEX. After passing through the light, turn right into the **first** parking lot on your right (this will be the Boutwell Chiropractic building). On the first floor of the Boutwell building there are two office suites. Crossroads is the office on the right.



PICTURE OF BOUTWELL BUILDING FROM ROAD SIDE

Confidential Client Intake Forms (Parent/Child)

Date: ___________________________

Parent Information:

Parents' Names: ____________________ ______________________ Age Male: ______ Age Female: _________

Address: ____ City/State: ____________________ Zip : _________

Primary Phone Numbers: ____ May we leave a message here: ❑ Yes ❑ No

Second Phone Numbers: ____ May we leave a message here: ❑ Yes ❑ No

Occupation / Employer: __________________________________ ____

Birth date: ______ / ______ / _________ Email Address: ____

Date of Marriage: _____________________________ Your ages when married: Husband _________ Wife ___________

List highest degree(s) earned: ________________________________ _______________________________________

School or Institution: ____ ___________________________________

Give **brief** information about any previous marriages:

Ex-Spouse's Name	Year Married	Length of Marriage	Reason for Divorce	# Kids

** Other relevant information can be written on the back of this page.*

Sibling's Names	Living	Age	Gender	At Home	Married	Special Condition(s)	*PM/A/MC
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		

** Check this column if child is by previous marriage (PM), adoption (A), or lost to miscarriage (MC).*

Minor Who Will Be in Counseling:

Name: ____ Age: ____________

Birth date: ______ / ______ / _________ Social Security Number: __________________________________

Nickname: ____ Email Address: __________________________ ______

Grade: _____ School: ____

Is your child coming to counseling voluntarily? Yes ❑ No ❑ Uncertain ❑

Has your child ever lived outside your home? Yes ❑ No ❑ When? ____________________________

If yes, where and how long? ____

Spiritual / Religious Information

DO YOU CONSIDER YOUR CHILD A RELIGIOUS PERSON ? Yes ❑ No ❑

Church Name: ____ Number of Years at Church: ___________

Pastor's Name: ____

Denominational Preference: _______________________ Church Attendance: _________ Times per month

Is your child a part of a Sunday School class? Yes ❑ No ❑ Is your child a part of a home Bible Study? Yes ❑ No ❑

Please list any ministry involvement: ____

HAS YOUR CHILD BEEN BAPTIZED? Yes ❑ No ❑ When?________________________________

Please answer the following questions with your parental assessment of your child's spiritual life.

DO YOU PRAY TO GOD? Yes ❑ No ❑ How often? ________________________________

What do you pray about? ____

HAVE YOU COME TO THE PLACE IN YOUR SPIRITUAL LIFE WHERE YOU KNOW WITH CERTAINTY THAT IF YOU WERE TO DIE TONIGHT YOU WOULD GO TO HEAVEN?

Yes ❑ No ❑ Uncertain ❑

If yes, what is your basis for answering the above question as you did? ____________________________

____

HAVE YOU RECEIVED JESUS CHRIST PERSONALLY AS YOUR SAVIOR?

Yes ❑ No ❑ Uncertain ❑ Don't know what you mean ❑

If yes, how do you know that Jesus Christ is your Savior? ________________________________

____

Do you read the Bible? Yes ❑ No ❑ How often? ________________________________

Do you have personal devotions? Yes ❑ No ❑ How often? ____________________________

Describe your personal devotions: ____

Do you have family devotions? Yes ❑ No ❑ How often? ____________________________

Describe your family devotions: ____

Please note any recent changes in your spiritual life: ______________________________

____

____

Health Information

Has your child had counseling, psychotherapy, or seen a psychiatrist before? Yes ❑ No ❑

Age	Duration	Counselor/ Center	Issue(s) / Topics(s) / Diagnosis	* Your Evaluation of Counseling

** Use back of this page if necessary or if you need more space*

Approximately how many hours of sleep does your child get each night? ________________________________

When do they normally: go to bed? ________ fall asleep? _________ wake up? _________ get out of bed? ________

What do they normally do between going to bed and falling asleep? ________________________________

Describe any recent changes in sleep habits: ________________________________

State of current health: Very good ❑ Good ❑ Average ❑ Declining ❑ Other: ____________________

Date of last medical examination: ____________________ Results: ________________________________

Current illness, injury, or disability: ________________________________

Is your child presently taking any medication? Yes ❑ No ❑ Prescribing Doctor(s): ____________________

Medication	Dosage	Frequency	Prescribed for…	Date began taking…

** Use back of this page if necessary*

Has your child used drugs for other than medical purposes? Yes ❑ No ❑ When?________________________

What? ________________________________ Amounts/Dosages: ________________________________

Do they drink alcoholic beverages? Yes ❑ No ❑ When? ____________________ How much? ______________

Describe their eating habits or changes in appetite: ________________________________

Describe their exercise routine: ________________________________

Current weight? ______ lbs Weight changes: **6 months** +/- ______ lbs **1 Year** +/- ______ lbs **5 Years** +/- _____ lbs

Number of non-working hours per week spent watching television ________ on computer _______ hobbies _______

Check any of the following words which best describe your child **at this time**:

___ Active
___ Ambitious
___ Self-Confident
___ Persistent
___ Nervous
___ Impatient
___ Impulsive
___ Moody
___ Blue
___ Excitable
___ Calm
___ Serious
___ Easy-going
___ Self-conscious
___ Good-natured
___ Extrovert
___ Likable
___ Leader
___ Submissive
___ Imaginative
___ Lonely
___ Shy
___ Sensitive
___ Introvert
___ Quiet

Please complete the following in one or two sentences:

1. Please describe the current problem, as you understand it. ____________________

____

____

____

____

2. What have you done about it (*most* effective and *least* effective)? ____________________

____

____

3. Other than counseling, what help are you seeking? ____________________

____

____

4. Who referred you to this ministry for help? ____________________

5. Please describe any family history (the family that you grew up in), which might be pertinent to the concerns that you bring to counseling (your relationship with your parents, their relationship with each other, significant losses and/or events): ____________________

____

____

____

6. Please list and describe key *positive* peer or role model relationships in your child's life ____________________

____

____

____

____

7. Please list and describe key *negative* peer or role model relationships in your child's life ____________________

____

____

____

____

8. What do you believe you will have to change to see the progress you desire? ____________________

____

____

9. Is there any other information we should know? ____________________

____

____

____

Crossroads Counseling Policy Review

Instructions for Policy Review: After carefully reading each policy please *place your initials* in the space provided to indicate your understanding and agreement with each policy. If you have questions please direct them to your counselor before your initial meeting. If for any reason you are unable to sign these forms, counseling services will be denied to you.

FINANCIAL POLICY

Crossroads is solely supported and able to operate because of your financial donations. The expenses of Crossroads are not underwritten by an individual, church, or corporation. Therefore, it is the responsibility of each counselee to maintain the operating expenses of Crossroads. The fair-market-value of counseling in the Augusta area ranges from $75.00 to $125.00 per 50-minute session. Your responsibility is to pray about the amount God would have you donate for the counseling you receive and be obedient to Him in your giving. Donations are expected at each visit.

***** Initial here if you understand and agree with this Financial Policy: __________**

APPOINTMENT CANCELLATION POLICY

We require a 24 hour notice if you wish to cancel or are unable to keep an appointment. E-mail is *not* an acceptable form of contact. If you fail to give us a 24 hour notice you will be expected to pay a missed appointment fee.

$25.00 for the first appointment missed or cancelled with insufficient notice.
$50.00 for the second appointment missed or cancelled with insufficient notice.
$75.00 for all subsequent appointments missed or cancelled with insufficient notice.

All clients are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to: (1) process payments at your request, (2) to bill for late cancellations or missed appointments, or (3) to reimburse Crossroads for returned checks. In each case you will be called and a message will be left (if answering service is available) before payments are processed. A $10.00 service charge is added to your donation for returned checks.

Credit Card Number: __________-__________-__________-__________ Exp Date: _______ / _______

Type of Card: ☐ MasterCard ☐ Visa

***** Initial here if you understand and agree with this Cancellation Policy: __________**

PHILOSOPHY OF CARE

We are committed to providing a balance in our approach to counseling. It is our belief that all inner conflicts are both psychological and spiritual, because your mind, emotions, and will are always involved and because God is always present and His Word is always applicable. It is our goal to provide the highest quality of care that meets your specific needs and honors Christ.

We believe that our past helps shape our present beliefs and behaviors and also influences future beliefs and behaviors. We will address some of the strategies that obstruct us, the foundational issues of our identity, and outline practical steps on how to live by faith, renew your mind, manage your emotions, and resolve emotional trauma of the past or present through faith and forgiveness.

When necessary we will work with your physician to ensure you receive the appropriate medical care in conjunction with the counseling services you receive.

***** Initial here if you understand and agree with this Philosophy of Care: __________**

CONFIDENTIALITY CLAUSE

The privacy and confidentiality of our conversations and records are a privilege of yours and are protected by our ethical principles in all but a few circumstances. Those exceptions are limited to the following: known or suspected child or elderly abuse; the intent to take criminal actions against another person; active suicidal ideations; and, counseling that is mandated by a legal authority, then it is assumed by your signature that you agree that your counselor may give/receive updates and opinions and share records for the purpose of professional continuity.

Your counselor reserves the right to consult with other counselors at Crossroads for the purpose of providing the highest level of care. As a para-church ministry, Crossroads reserves the right to involve the church where you hold membership for the purpose of cooperative pastoral care.

In each counseling office and in the waiting room at Crossroads there are closed circuit video cameras. These cameras record picture only. They do not record voice. Video tapes are securely stored and made a part of Crossroads permanent records. Cameras are used exclusively for office protection and liability reduction.

***** Initial here if you understand and agree with this Confidentiality Clause: __________**

WAIVER OF LIABILITY

In seeking counseling from *Crossroads Counseling*, you must acknowledge your understanding of the following conditions and further release *Crossroads Counseling*, its agents, affiliates, counselors, employees, Board of Directors, and all ministry team leadership, from any legal liability, claim, or litigation arising from your participation in this voluntary program:

1. Counseling will be provided by ordained ministers or counselors licensed by the Georgia Board of Examiners for Christian Counselors and Therapists (Brad Hambrick, M.Div., Th.M.) or a counselor from a pastoral perspective (Celeste Vernon, M.A.). The counseling staff is *not* a state licensed counselor through the Georgia Composite Board;
2. All counseling is provided in accordance with the biblical principles adhered by *Crossroads Counseling* and are not necessarily provided in adherence to any local or national psychological or psychiatric association;
3. No representation has been made, either expressly or implied, that the biblical counseling, as conducted by the above mentioned counselors, is accepted as customary psychological and/or psychiatric therapy within the definitional terms utilized by those professions;
4. It is understood by the participant counselee(s) that all complaints and grievances will be heard by the Executive Director. If the goal of reconciliation cannot be achieved between the aforementioned parties, then the participant counselee(s) may elect to involve *Peacemaker Ministries, Inc.,* at their expense, for the purpose of mediation or arbitration.

***** Initial here if you understand and agree with this Waiver of Liability: __________**

CONSENT TO COUNSEL

Having read and understood *Crossroads Counseling*'s

❑ Financial Policy ❑ Appointment Cancellation Policy ❑ Confidentiality Clause
❑ Waiver of Liability ❑ Philosophy of Care

I, ____ (print name)

grant permission for *Crossroads Counseling* to render counseling services to me and the names listed below (please include the names of those who may be involved in the counseling process):

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

I also understand that *Crossroads Counseling* may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, or for other issues agreed upon by the Board of Directors.

* * * * * * * * * * * * *

Please sign to indicate the following:

1. You have read the policies in this document;
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into counseling of your own will.

____ _____________________________

Client Signature Date

____ _____________________________

Client Signature (*if more than one client*) Date

____ _____________________________

Crossroads Counselor Signature Date

Confidential Client Intake Forms (Minor)

Date: ______________________

Name: ______________________ ______________ Gender: Male / Female Age: ______

Address: ______________________ ______________ City/State: ______________ Zip : ______

Grade in School: __________ School: ______________________________________

Birth date: _____ / _____ / _______ Email Address: ______________________________

What are your thoughts about coming to counseling? ______________________________

____

____

SPIRITUAL / RELIGIOUS INFORMATION

Church Name: ______________________________ Church Attendance: ______ Times per month

DO YOU PRAY TO GOD? Yes ❑ No ❑ How often? ______________________________

What do you pray about? ____ ______

HAVE YOU COME TO THE PLACE IN YOUR SPIRITUAL LIFE WHERE YOU KNOW WITH CERTAINTY THAT IF YOU WERE TO DIE TONIGHT YOU WOULD GO TO HEAVEN?
Yes ❑ No ❑ Uncertain ❑

If yes, what is your basis for answering the above question as you did? ______________________ _____

____ ____

Do you read the Bible? Yes ❑ No ❑ How often? ______________________________

Please note any recent changes in your spiritual life: ______________ ______________

____

OTHER INFORMATION

Please provide the following information about your home:

If you were reared by someone other than your own parents, briefly explain: ______________________

____

Number of older brothers: _____ Older Sisters: _____ Younger brothers: _____ Younger Sisters: _____

Step/half: _____ Step/half: _____ Step/half: _____ Step/half: _____

The town I grew up in was ____ urban ____ suburban ____ small town ____ rural ____ changed frequently.

My family's financial situation was ___ poor ___ lower middle ___ middle class ___ upper middle class __wealthy.

Did you have any significant traumatic events as a child? ___ Yes (*please describe on back*) ___ No

Which of the following words best describe your home of origin (check all that apply):

___ Traditional ___ Authoritarian ___ Calm ___ Divorced ___ Lonely
___ Substance Abuse ___ Physical Abuse ___ Verbal Abuse ___ Perfectionist ___ Critical
___ Sexual Abuse ___ Affectionate ___ Affirming ___ Safe ___ Permissive
___ Unpredictable ___ Always Changing ___ Boring ___ Other:______________

Check any of the following words which best describe you **at this time**:

___ Active	___ Impatient	___ Calm	___ Extrovert	___ Lonely
___ Ambitious	___ Impulsive	___ Serious	___ Likable	___ Shy
___ Self-Confident	___ Moody	___ Easy-going	___ Leader	___ Sensitive
___ Persistent	___ Blue	___ Self-conscious	___ Submissive	___ Introvert
___ Nervous	___ Excitable	___ Good-natured	___ Imaginative	___ Quiet

Check any of the following struggles or difficulties that you are experiencing **at this time**:

___ Anger	___ Parents on my back	___ Eating Disorder	___ In-Laws
___ Anxiety	___ Depression	___ Guilt	___ Fear
___ Apathy	___ Marital Intimacy	___ Chronic Pain	___ Envy
___ Bitterness	___ Moodiness	___ Homosexuality	___ Rebellion
___ Lifestyle Change	___ Memory Loss	___ Addiction	___ Deceit
___ Pornography	___ Financial Management	___ Suicidal Thinking	___ Grief
___ Communication	___ Peer Pressure	___ Panic Attacks	___ Work
___ Conflict Resolution	___ Relationships	___ Bad Memories	___ Purpose
___ Security	___ Compulsions	___ Self-Injury	___ Identity
___ Procrastination	___ Time Management	___ Codependency	___ Family
___ Responding to Abuse (Type: ________________)		___ Psychological Diagnosis (______________)	

Please complete the following:

In order to understand me ____

My ambition in life is to ____

What really hurts me ____

I get nervous when ____

I wish I could lose my fear of ____

What I wish I could change about myself ____

My *best* childhood memory ____________________________________ ___________________________

My *worst* childhood memory ____

My father is/was ____

My mother is/was ____________________ ____

My biggest regret is ____

What I like/understand least about the opposite sex is ____________________________________

My greatest achievement is ____

My role in my current family is ____ _

For refuge/rest I turn to _________________________________ ______________________________

When life gets too hard I ____

To be happy I need ____

I would do anything for ____

I often wonder why ____

It embarrasses me to ____

I cannot decide ____

Please describe the current problem, as you understand it. _______________ ____________________

____

____

What have you done about it? _________________ ____

____

Is there any other information we should know? ______________ ___________________________

____

____