Sacred Journey Counseling
5400 W. Plano Parkway, Suite 210, Plano, TX 75093 ● www.SacredJourneyCounseling.com

Professional Disclosure Statement and Couple/Partner Intake

Nature of Counseling

Our approach to counseling focuses on how the influences of the past affect the decisions and interactions you are having today. Throughout your therapy, together you and we will look at the different aspects of your personality, how you were raised, the messages you received from your parents, and how you functioned in the family system. In addition, both of us will work on counseling goals, which will govern the direction of your counseling process. Through directive techniques focusing on the here and now, we will work towards fostering your self-awareness, self-responsibility, and genuineness.

Some clients need only a few counseling sessions to achieve their goals, others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though we do ask that you participate in a termination session. You also have the right to refuse or negotiate modification of any of our suggestions that you believe might be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques.

Sessions are usually held weekly for about 45 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions you arrange with me except in case of emergency when you may contact me by phone. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than the professional context or our counseling sessions. You will be best served if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me in my professional role only. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

Referrals

If at any time, for any reason, you are dissatisfied with my service, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 512-834-6658. Should you and/or I believe that a referral is needed, I will provide some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon request.

Fees and Cancellation

In return for a fee of $_____ (will be agreed upon) per session, I agree to provide counseling services for you. The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks (made out to Stacie Smith) are acceptable forms of payment. We also provide credit card services, with a nominal convenience fee attached. If the fee represents a hardship to you, please let me know.

In the event that you will not be able to keep an appointment, please cancel at least 24 hours in advance. If proper notice is not received, you are responsible for the complete payment for the missed session.

Telephone Counseling
We as an agency want to support you at every step you are needing support. There may be times when you need to ask some questions, gain some reassurance, or get feedback. There will not be a charge for calls that happen one time in a 30-day period of a maximum 15 minutes. Support that exceeds the 15 minutes or needing support more than one time per month will be charged at the agreed upon hourly rate.

Returned Checks
Checks that do not clear at the bank will need to be reimbursed within 48 hours plus a $36.00 servicing fee. If your check does not clear on three or more occasions, you will be required to pay in cash.

Court Testimony
We as an agency are not interested in appearing in court for any reason. If we are subpoenaed to testify, you will be expected to pay in advance a $5,000.00 retainer fee. In the event that we are required to testify, there will be a fee of $160.00 per hour for each clinical hour spent preparing and testifying, as well as any driving time or waiting time. If, at any time, you believe you are going to need to appear in court, we are happy to refer you to a new clinician who is willing and trained to support you in this way.

Emergency Sessions
There are times in which you may need a session during the weekend hours or on a day your clinician is not working. In the event that you need a session outside of your clinician's hours, you may request an emergency session with an additional $20.00 emergency fee to be added to our agreed upon fee.

Written Documentation
There are times when you may need written documentation provided. In the event that you need a letter written, there will be a service charge of $30.00/30 minutes for the clinician's time.

Records and Confidentiality
All of our communication becomes part of the clinical record, which is accessible to you on request. I will keep confidential anything you say to me, with the following exceptions:

a. I determine that you are a danger to yourself and/or others;
b. I am ordered by a court of law to disclose information;
c. You disclose sexual contact with another health professional;
d. You sign a release for me to tell someone else; and/or,
e. You disclose information regarding physical harm to a minor.

Client's Signature	Clinician's Signature
Date	Date

Couple/Partner Intake

The requested information will become part of your file and is limited to the guidelines of confidentiality.

Name (First MI Last): _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: ☐Same as Physical Address; _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Preferred Contact Method for Session Reminders or Scheduling:
☐Home Phone ☐Work Phone ☐Cell Phone ☐Text ☐Email

Emergency contact:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Who referred you for Counseling Services? _____

What do you hope to gain from counseling? _____

_____

_____

Occupation

Employer: _____

Position: _____ How long have you been at your present job? _____

Kinds of jobs held in the past: _____

_____

_____

What do you enjoy about your present job? _____

_____

_____

What do you not enjoy about your present job? _____

_____

_____

What are your work ambitions? _____

_____

_____

Have you ever been fired from a job? ☐Yes ☐No If yes, please explain the circumstances: _____

_____

_____

Have you served in the military? ☐Yes ☐No If yes, Branch of Service: _____

Service Dates: _____ Type of Separation: _____

Education

Highest level of education completed: _____ Degree(s) conferred: _____

Do you have any further education goals? ☐Yes ☐No If so, what might those be? _____

_____

_____

Family of Origin

Father's Name: _____ ☐ Living ☐ Deceased

If Deceased, age you were when it happened and how you processed it: _____

_____

His Occupation: _____

How would you describe your father? _____

_____

What is/was his attitude toward you? _____

_____

How would/did he describe you? _____

_____

Do you have or did you have a step-father? ☐ Yes ☐ No Ages? _____

Mother's Name: _____ ☐ Living ☐ Deceased

If Deceased, age you were when it happened and how you processed it: _____

_____

Her Occupation: _____

How would you describe your mother? _____

_____

What is/was her attitude toward you? _____

_____

How would/did she describe you? _____

_____

Do you have or did you have a step-mother? ☐ Yes ☐ No Ages? _____

Please list your siblings by names and ages, from oldest to youngest. Include yourself in the listing.

1. _____ 5. _____ 9. _____

2. _____ 6. _____ 10. _____

3. _____ 7. _____ 11. _____

4. _____ 8. _____ 12. _____

Who do you feel closest to in your family currently? _____

As a child, who gave you the greatest caring and support? _____

Have any significant family members died? ☐ Yes ☐ No If yes, indicate who they were and your age when they died? _____

_____

Has anyone in your family suffered from alcoholism, mental disorders, severe depression, or anything that might be considered a serious illness? ☐ Yes ☐ No Please name the family member, relationship, and illness. _____

_____

Relationships

Are you currently involved in an intimate relationship with another person? ☐ Yes ☐ No If yes, please indicate nature (married, dating, etc.) and duration: _____

Partner's age: _____ Partner's occupation: _____

Personality of your partner: _____

In what ways is there compatibility? _____

_____

In what ways is there incompatibility? _____

_____

What is the reason you are coming with your partner for counseling? _____

_____

What is your opinion of what is not working in your relationship? _____

_____

What is your opinion of what is working in your relationship? _____

_____

How would you describe your partner? _____

How would your partner describe you? _____

What do you do to sabotage your relationship with your partner? _____

_____

Have you or your partner had an affair during this relationship? ☐ Yes ☐ No If yes, who had the affair, is it over, how long has it been over? _____

_____

Do you or your partner have any known addictions? ☐ Yes ☐ No If yes, please describe. _____

_____

Is there or has there been emotional violence in your relationship? ☐ Yes ☐ No If yes, please describe. _____

Is there or has there been physical violence in your relationship? ☐ Yes ☐ No If yes, please describe

_____

Is there or has there been sexual violence in your relationship? ☐ Yes ☐ No If yes, please describe

_____

Please rate your degree of satisfaction in the following areas of your relationship:

	Unsatisfied						Satisfied
Communication	1	2	3	4	5	6	7
Honesty	1	2	3	4	5	6	7
Child Raising	1	2	3	4	5	6	7
Financial Decisions	1	2	3	4	5	6	7
Sexual Relationship	1	2	3	4	5	6	7
Other: _____	1	2	3	4	5	6	7

List your children by name, sex, and age from oldest to youngest:

1. _____ 5. _____ 9. _____

2. _____ 6. _____ 10. _____

3. _____ 7. _____ 11. _____

4. _____ 8. _____ 12. _____

Do any of your children present special problems? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Have you lost any children? ☐ Yes ☐ No If yes, please offer information regarding the loss that will be helpful to your treatment. _____

_____

_____

Do you have people in your life that you consider very close friends? ☐ Yes ☐ No ☐ Maybe

Please name these friends: _____

_____

Do you have a support system you can turn to in times of need (church, Alanon, AA, etc.)? ☐ Yes ☐ No

If yes, name this system: _____

Health

Physician: _____

Address: _____

Phone: _____ Fax: _____

Do you have any significant health problems? ☐ Yes ☐ No If yes, please describe and offer prognosis

_____

_____

_____

List any current medications and what each treats: _____

_____

_____

_____

Please list other medications that you take with some frequency (including such things as aspirin, decongestants, birth control pills, valium, sleeping pills, diet pills, etc.) _____

_____

_____

Please list any surgeries you have had and the age you had it? _____

_____

_____

Please list any other hospitalizations, even visits to the emergency room, include reason and age: _____

_____

_____

_____

_____

Please list any other health concerns not previously discussed: _____

_____

Have you experienced any significant weight loss or gain? ☐ Yes ☐ No If yes, please indicate year(s) of these occurrences and the amount of change: _____

_____

Do you exercise regularly? ☐ Yes ☐ No Type: _____

Do you smoke? ☐ Yes ☐ No If so, how often and how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, _____ times per week and _____ drinks per time.

Drink of choice: _____ Do you binge drink? ☐ Yes ☐ No

Do you take drugs? ☐ Yes ☐ No If yes, describe your drug history, how often, age began, what types and age stopped, if stopped, and what you did to stop? _____

_____

_____

Have you ever had a problem with alcohol or drugs? ☐ Yes ☐ No

Legal

Have you ever been arrested? ☐ Yes ☐ No If yes, please describe: _____

_____

_____

Have you ever been convicted of an offense other than a minor traffic violation? ☐ Yes ☐ No If yes, when and for what? _____

_____

_____

Have you experience any other legal problems? ☐ Yes ☐ No If yes, please describe: _____

_____

Personal

Please check any of the following that apply to you:

☐ Anorexia	☐ Anxiety	☐ Being dramatic	☐ Bowel problems
☐ Bulimia	☐ Can't cry	☐ Cry often	☐ Debt
☐ Depression	☐ Dizziness	☐ Feel inferior	☐ Feel insecure
☐ Grief	☐ Headaches	☐ Impulsiveness	☐ Incest
☐ Insomnia	☐ Lying	☐ Molestation	☐ Nightmares
☐ Obsessions	☐ Often angry	☐ Panic attacks	☐ Paranoia
☐ Rape	☐ Sexual problems	☐ Stealing	☐ Stomach trouble
☐ Suicidal ideas	☐ Unable to relax	☐ Violence	☐ Worrying

List your 5 main fears: _____

_____

_____

Present interests, hobbies, activities: _____

_____

_____

What are the goals in your life? _____

_____

_____

Briefly describe your religious beliefs: _____

_____

_____

Are there problems with your sex life? ☐ Yes ☐ No If yes, what? _____

Have you had sexual problems before? ☐ Yes ☐ No If yes, what? _____

Do you feel you have some unusual or uncommon sexual practices? ☐ Yes ☐ No

Have you ever felt suicidal? ☐ Yes ☐ No If yes, when did you last feel suicidal? _____

Have you sought counseling before? ☐ Yes ☐ No If yes, please indicate, name of therapist, what years or months in therapy, and what issues processed? _____

_____

_____

_____

Has anyone close to you died? ☐ Yes ☐ No If yes, who, and how old were you at the time? _____

_____

_____

Have you experienced other losses in your life (i.e., divorces, bankruptcy, child who is alienated from

you, etc.)? ☐ Yes ☐ No If yes, please describe. _____

_____

Do you have any resentment? ☐ Yes ☐ No If yes, please describe. _____

_____

What was the best period of your life and why? _____

What was the worst period of your life and why? _____

What do you worry about most? _____

_____

After you die, how would you like to be remembered? _____

_____

Please rate your degree of satisfaction in the following areas of your life:

	Unsatisfied						Satisfied
Job	1	2	3	4	5	6	7
Primary Relationship	1	2	3	4	5	6	7
Child Raising	1	2	3	4	5	6	7
Financial Decisions	1	2	3	4	5	6	7
Sexual Relationship	1	2	3	4	5	6	7
Educational	1	2	3	4	5	6	7
Health	1	2	3	4	5	6	7
Spiritual	1	2	3	4	5	6	7
Friends	1	2	3	4	5	6	7
Self-esteem	1	2	3	4	5	6	7
Other: _____	1	2	3	4	5	6	7

What do I need to know but have not asked? _____

_____

How are you likely to sabotage your therapy? _____

_____