



Sacred Journey Counseling

5400 W. Plano Parkway, Suite 210, Plano, TX 75093 • www.SacredJourneyCounseling.com

Professional Disclosure Statement and Individual 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.

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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

Adult 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.

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1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
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? _____

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:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Being dramatic | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Can't cry | <input type="checkbox"/> Cry often | <input type="checkbox"/> Debt |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feel inferior | <input type="checkbox"/> Feel insecure |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Headaches | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Incest |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Lying | <input type="checkbox"/> Molestation | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Obsessions | <input type="checkbox"/> Often angry | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Rape | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Stealing | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Suicidal ideas | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Violence | <input type="checkbox"/> 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
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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? _____