Eagles Landing Christian Counseling Center, Inc. * Main Campus 1944 Brannan Rd. * McDonough, Georgia * 30253 * 678-289-6981

Adult Group Intake Information

Welcome to Eagle's Landing Christian Counseling Center! We know that you have many options for behavioral health care, and we appreciate your choosing our team to assist you. On the following pages, please take time to tell us about you. Please complete this before your first session and your counselor will then review this information together with you in your first and subsequent sessions.

Client Information (Please Print)

Name: _____ Today's Date: _____

Gender: M F Age: _____ Date of Birth: _____

Telephone: Home: _____ Work: _____

Mobile:_____ Pager/Other: _____

Address (No. & Street/P.O. Box): _____ Apt. _____

City: _____ State: _____ Zip: _____

E-mail: _____

Calls or e-mail will be discreet; please note any restrictions: _____

Where would like to have appointment reminders? _____

Religious Affiliation: _____ Church: _____ Active: Y N

Employment Status: Full-time Part-time Unemployed Retired
Occupation: _____ Employer:_____
Employment Address: _____

Education/Training: Current Student: Y N Full-time Part-time Grade/College Yr. ___
School (If presently enrolled): _____ Years of Education: _____
Degree(s) Earned: _____

Military Service: Y N Branch: _____ MOS: _____Discharge Date: _____

In case of emergency, please contact: Name: _____
Relationship: _____ Telephone: _____

Referred by: _____

Are you currently seeing another counselor or psychiatrist? Y N
If yes, Name: _____ Phone: _____
Have you been in counseling before? Y N If yes, when and for how long?_____

Health Information

Rate your current physical health: Excellent Good Average Declining Poor

Height: _____ Weight: _____ Recent Weight Changes: (lbs) lost: _____ gained:_____

Do you have any illnesses, injuries, or disabilities (past or present – including problems at birth) that we should know about:

_____

_____

Name of Primary Care Physician/Clinic: _____

Address: _____ Telephone:_____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes ____ No ____

Please list ALL medications (prescription or over-the-counter) that you are currently taking (If necessary, use additional page to list ALL current medications.):

_____

_____

_____

What kinds of physical exercise do you get? How often? _____

How much caffeine do you consume each day? _____

Do you try to restrict your eating in any way? How? Why? _____

Do you smoke? Yes No If yes, what and how much per day/week/month?

_____

Do you drink alcohol? Yes No If yes, what and how much per day _____ week____ month ___ year_____?

Does your drinking concern you? Yes No

Does anyone else complain about your drinking? Yes No

If yes, who complains? _____ Why? _____

Do you participate in any risky behaviors? Yes or No If so, what kind? _____

Marital Status: Single Engaged Married Separated Divorced Widowed

Name of Spouse: _____ Age:_____ How long married? _____

Children:

	Name	Age	Gender	Grade	Health
1.					
2.					
3.					
4.					

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Family-of-origin:

	Name	Age (or age at death)	Health (or cause of death)	Where living
Father:				
Mother:				
Sibling:				
Sibling:				
Sibling:				

Note other immediate family members, i.e. step-parents, step-siblings: _____
_____

Spiritual Information:

I consider myself: Christian Jewish Buddhist Muslim Hindu Agnostic Atheist Other Unknown
I am happy with my current spiritual journey: Yes No Why? _____
I am active in the practice of my faith: Yes No Why? _____
I am visiting a Christian Counseling Center because: (Circle the number of all that apply)
1) I hope to get counseling from a Christian perspective;
2) I am open to hearing a Christian perspective on my issues;
3) I was referred here by a friend who was helped and hope to have the same good result;
4) This is a Christian counseling center? What does that mean?

For Women Only: (men skip to "Reason for Today's Visit")

At what age did you start to menstruate (get your period)? _____
How regular are your periods? _____ How long do they last? _____ Heavy ____ Light ____
How much pain do you have? _____ Other experiences during period: _____
PMS experiences: _____

If your menopause has started, at what age did it start? _____ What menopausal signs or symptoms have you experienced? _____

Have you had a hysterectomy? Y N At what age? ___ Are you taking Hormone Replacement Therapy? Y N Type: _____

Please list all of your pregnancies and what happened with these pregnancies (your age, type of birth, miscarriage, abortion, any problems):_____
_____
_____
_____

Reason for Today's visit:

In your own words, briefly describe the main problem which prompted you to seek counseling at this time: _____
_____
_____
_____
_____
_____
_____
_____
_____

Checklist of Concerns:

Circle any LOSSES that you have experienced:

Death of: spouse child father mother sister brother grandmother grandfather friend; Divorce; Separation; Broken engagement; Miscarriage; Abortion; Infertility; Bankruptcy; Homelessness; Career/Job loss; Other:_____

Circle any of these EXPERIENCES you have had in your life:

Child abuse: Physical, Emotional, Sexual, Incest From: Father, Mother, Sibling, Stepfather, Stepmother, Step Sibling, Uncle;
Spouse abuse: Physical, Emotional, Sexual, From which relationship? Spouse's drug or alcohol problems; Spouse's mental illness; _____;
From Parents: divorce; drug or alcohol problems; mental illness; Foster care; Abandonment; Rape; ; Assault; Suicide attempt;
Other: Auto or industrial accident; Major illness; Robbery Major surgery; Other:_____

Circle any PROBLEMS that concern you now:

Relationships	Alcohol	Drugs	Binge eating	diet or exercise
Work too much	Shopping	Anger	Loneliness	Suicidal-thoughts
Procrastination	Depression	Grief	Mood swings	dependency
Communication	Career	Sex	Self-esteem	Health problems
Sexual thoughts	Anxiety	Stress	Energy	Legal matters
Sleep problems	Relaxation	Fear	Temper	Self-control
Loss of Appetite	Memory	Parenting	Finances	Nightmares
Concentration	My thoughts	Feelings God	Other: _____	

Any other concerns or issues:_____
_____
_____
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Notes:
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Financial Policy and Agreement for Professional Services

Financial Policy and Agreement for Professional Services

Thank you for choosing **Eagle's Landing Christian Counseling Center** as your biblically-based therapeutic provider. We are committed to the success of your treatment. We are a non-profit organization. While keeping fees as low as possible, our counselors still need to be reimbursed for their services. Lower cost consultation is available from time to time with our interns. Below you will find the details of our financial policy. A signed agreement to this policy is required before beginning treatment.

1-A. GENERAL FINANCIAL POLICIES FOR ALL CLIENTS:

- Payments are due at the time of service. For group participation, payment is due in advance for 4 week increments. Please pay the receptionist or service provider at your intake meeting. We accept payment by cash, check, debit, Visa, Discover, and MasterCard.
- A $30.00 fee is charged for any checks returned from the bank for *any* reason and is due in cash at your next session.
- All checks should be made payable to: Eagle's Landing Christian Counseling Center, or ELCC.
- Group sessions are 60-90 minutes long. Additional individual sessions related to the group will incur a cost of $35 per session.
- Phone conversations that exceed 20 minutes in length are charged a one-session fee.

1-B. MISSED OR CANCELLED Group sessions:

- Please help us better serve you by keeping scheduled appointments. Group fees will not be refunded but can be applied to future group participation if cancellation is made 24 hours in advance.
- Exceptions will be made in the event of an accident or an emergency [i.e.., breaking down, sudden illness, or sudden illness of a minor child, etc. Please note that "having to work" is not considered an emergency.]

1-C. LATE ARRIVALS OF CLIENTS AND/OR THERAPIST RUNNING LATE:

- We understand that sometimes things happen and you may arrive late for the group. After 30 minutes, you may or may not be allowed to enter the group session due to activities already going on. Please call the center if you are running late to let the group leader know your anticipated arrival time. (678-289-6981)

1-E. GUARANTEES:

- I understand that there are no guarantees given or implied that my issues will be completely resolved.

II. I hereby attest to the fact that I have thoroughly read all the above information and I have completed the questionnaire fully to the best of my knowledge. I do hereby voluntarily request the counseling services of Eagle's Landing Christian Counseling Center, in accordance with the terms stated herein.

Name: _____ Date: _____

Informed Consent

Please Read Each Item Listed Below And Initial Each Indicating Agreement:

— I will maintain the confidentiality of anyone I see in the counseling office or in my group.

— I agree to conduct myself in an appropriate manner. Small children must be attended at all times.

— I agree to cancel group appointments 24 hours in advance. I understand that I will not receive a refund for missed groups or those cancelled in less than 24 hours, except in an emergency (sudden illness, car accident on the way to the office, etc. "I have to work" is not considered an emergency).

— I understand that physical abuse, sexual abuse, neglect, of children (under 18 years of age) or endangerment through the witnessing of domestic violence must be reported by law.

— I understand that physical abuse, sexual abuse, or neglect of the elderly (65 years and older) or disabled must be reported by law.

— I understand that intent to do harm to another person will be reported to that person and the police.

— I understand that group session lengths are 60-90 minutes.

— I agree to discuss issues only during designated appointments and not during the therapist's personal time. If I have a psychological emergency related to my treatment, I understand that I may contact my therapist on his/her after hours number found on their business card or for more urgent psychiatric car I may call Crescent Pines Hospital at (770) 474-8888.

— I understand that no information about me or my issues will be disclosed to anyone outside of the Counseling center. However, for the purposes of supervision, billing, and training, *some* information may be shared with other staff.

II. I hereby attest to the fact that I have thoroughly read all enclosed information and I have completed the questionnaire fully to the best of my knowledge. I do hereby voluntarily request the counseling services of Eagle's Landing Christian Counseling Center, in accordance with the terms stated herein. Specifically, I request that the therapist named below provide professional services to myself, (print name) _____, and I agree to pay this therapist's fee of $ 25 per session in 4 week increments of $100 and I understand that insurance will not cover these services.

_____ _____
Signature of Client (or person acting for client) Date

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give information and willing consent.

_____ _____
Signature of Therapist Date

_____ Client's copy _____ Therapist's copy

Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: _____ DOB: _____
I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Eagle's Landing Christian Center, hereinafter referred to as "ELCCC" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by ELCCC may be conditioned upon my consent as evidenced by my signature on this document.
I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and ELCCC.

I have the right to revoke this consent, at any time, in writing, except to the extent that ELCCC or the practice has taken action in reliance on this consent.
My "protected health information" means health information, including my demographic information, collected from me and created or received by ELCCC, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 1944 Brannan Rd. McDonough, GA 30233. As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Personal Representative:

_____ _____
Description of Personal Representative's Authority Date

Limits of the Therapy Relationship: What Clients Should Know

Psychotherapy is a professional service I can provide to you. Because of the nature of therapy, our relationship has to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of therapist and client only. If we were to interact in any other ways, we would then have a "dual relationship," which would not be right and may not be legal. The different therapy professions have rules against such relationships to protect us both.

I want to explain why having a dual relationship is not a good idea. Dual relationships can set up conflicts between my own (the therapist's) interests and your (the client's) best interests, and then your interests might not be put first. In order to offer all my clients the best care, my judgment needs to be unselfish and professional.

Because I am your therapist, dual relationships like these are improper:

- I cannot be your supervisor, teacher, or evaluator.
- I cannot be a therapist to my own relatives, friends (or the relatives of friends), people I know socially, or business contacts.
- I cannot provide therapy to people I used to know socially, or to former business contacts.
- I cannot have any other kind of business relationship with you besides the therapy itself. For example, I cannot employ you, lend to or borrow from you or trade or barter your services (things like tutoring, repairs, child care, etc.) or goods for therapy.
- I cannot give legal, medical, financial, or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client.

There are important differences between therapy and friendship. As your therapist, I cannot be your friend. Friends may see you only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may need to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that therapists are required to keep the identity of their client's secret. Therefore, I may ignore you when we meet in a public place, and I must decline to attend your family's gatherings if you invite me. Lastly, when our therapy is completed, I will not be able to be a friend to you like your other friends.

In sum, my duty as therapist is to care for you and my other clients, but only in the professional role of therapist. Please note any questions or concerns on the back of this page so we can discuss them.

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