JOURNEY ON COUNSELING
ADULT INFORMATION FORM
(PLEASE PRINT)

In order to serve you better, we request that you take a few moments to fill out the following information.

Last Name _____First Name_____ M.I._____

Mailing Address_____ City _____ State _____ Zip_____

May we write to you at your home? ( ) Yes ( ) No

May we leave a message at the following numbers? Home: _____ ( ) Yes ( ) No

Cell Phone: _____ ( ) Yes ( ) No Work: _____ ( ) Yes ( ) No

Email: _____ Date of Birth _____ Age _____

Sex: ( ) Male ( ) Female

Occupation - Self: _____ Spouse: _____

Current Marital Status: ( ) Never Married ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Name of Spouse (if applicable) _____ Date of Marriage _____

PREVIOUS MARITAL HISTORY:

Self:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Spouse:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION

Self: ( ) GED ( ) High School Diploma ( ) College Degree ( ) Graduate Degree

Degree Obtained _____

Spouse: ( ) GED ( ) High School Diploma ( ) College Degree ( ) Graduate Degree

Degree Obtained _____

Children: Name Gender Age Father's/Mother's First Name

_____ ( ) M ( ) F _____ _____

_____ ( ) M ( ) F _____ _____

_____ ( ) M ( ) F _____ _____

_____ ( ) M ( ) F _____ _____

PERSONAL INFORMATION:

Are you currently attending church? ( ) Yes ( ) No If so, where? _____

Are you a born-again Christian? ( ) Yes ( ) No ( ) Unsure

Briefly describe your relationship with Christ:

_____

_____

_____

Are religious or spiritual issues important in your life? ( ) Yes ( ) No

Are there any religious or spiritual resources in your life that could be used to help you overcome your problems?

( ) Yes ( ) No If so, what are they? _____

How were you referred? _____

How would you rate your overall health? ( ) excellent ( ) good ( ) fair ( ) poor

How many hours do you sleep each night? _____ Do you experience food cravings? ( ) Yes ( ) No

If so, for what items? _____

How would you rate your diet? ( ) Very Healthy ( ) Healthy ( ) Average ( ) Needs Improvement ( ) Poor

Are you currently on medication? ( ) Yes ( ) No If so, please complete the following:

Medication	*Dosage*	*Physician*	*Purpose*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL CONCERNS:

What is your main concern that brought you in today?

_____

_____

_____

How much are you troubled by this? ( ) Constantly ( ) Often ( ) Somewhat ( ) Not Very Much

Comments concerning this problem:

_____

_____

_____

PREVIOUS COUNSELING HISTORY:

Have you received Counseling Services here before? ( ) Yes ( ) No

Who was the counselor? _____

What was the main concern?

_____

_____

_____

Please list all previous counselors prior to coming today:

Who was the counselor? _____

What was the main concern?

_____

_____

_____

Who was the counselor? _____

What was the main concern?

_____

_____

_____

Who was the counselor? _____

What was the main concern?

_____

_____

_____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless. ___ Never ___ Rarely ___ Sometimes ___ Frequently
2. I am lonely. ___ Never ___ Rarely ___ Sometimes ___ Frequently

3. No one cares about me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
4. I am a failure. ___ Never ___ Rarely ___ Sometimes ___ Frequently

5. Most people don't like me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
6. I want to die. ___ Never ___ Rarely ___ Sometimes ___ Frequently
7. I want to hurt someone. ___ Never ___ Rarely ___ Sometimes ___ Frequently
8. I am so stupid. ___ Never ___ Rarely ___ Sometimes ___ Frequently

9. I am going crazy. ___ Never ___ Rarely ___ Sometimes ___ Frequently
10. I can't concentrate. ___ Never ___ Rarely ___ Sometimes ___ Frequently
11. I am so depressed. ___ Never ___ Rarely ___ Sometimes ___ Frequently
12. God is disappointed in me. ___ Never ___ Rarely ___ Sometimes ___ Frequently

13. I can't be forgiven. ___ Never ___ Rarely ___ Sometimes ___ Frequently
14. Why am I so different? ___ Never ___ Rarely ___ Sometimes ___ Frequently
15. I can't do anything right. ___ Never ___ Rarely ___ Sometimes ___ Frequently
16. People hear my thoughts. ___ Never ___ Rarely ___ Sometimes ___ Frequently

17. I have no emotions. ___ Never ___ Rarely ___ Sometimes ___ Frequently
18. Someone is watching me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
19. I hear voices in my head. ___ Never ___ Rarely ___ Sometimes ___ Frequently
20. I am out of control. ___ Never ___ Rarely ___ Sometimes ___ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

SYMPTOMS

Please check the behavior and symptoms that occur to you more often than you would like them to take place.

___ Aggression
___ Alcohol Dependence
___ Anger
___ Antisocial Behavior
___ Anxiety
___ Avoiding People
___ Chest Pain
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug Dependence
___ Eating Disorder
___ Fatigue
___ Hallucinations
___ Heart Palpitations
___ High Blood Pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment Errors
___ Loneliness
___ Memory Impairment
___ Mood Shifts
___ Panic Attacks
___ Phobias/Fears
___ Sexual Difficulties
___ Sick Often
___ Sleeping Problems
___ Speech Problems
___ Suicidal Thoughts
___ Thoughts Disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (Specify)
_____
_____
_____

___ Elevated Mood ___ Recurring Thoughts _____

Please give examples of how each of the symptoms that you checked impairs your ability to function (i.e., socially, emotionally, occupationally, physically, etc.) Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

Whom should we contact in case of an emergency?

Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

THANK YOU FOR CHOOSING
JOURNEY ON COUNSELING!

INFORMED CONSENT

COUNSELING RELATIONSHIP

We appreciate the fact that you have chosen us to walk with you through the counseling process. We recognize that your participation is voluntary and know that you have the right to terminate at anytime. However, our goal for you is for full participation so that you may gain the most out of the counseling process. This includes consistent attendance, being on time and ready to go at the start of each session with your homework already completed. We trust that your commitment to these essentials of counseling will help play a valuable role in bringing about the change that you so desire.

Furthermore, we are completely committed to walking alongside you as you seek out change from a biblical perspective that ultimately draws you closer to God. As part of that commitment, it is extremely important to note that God is the only one that can and will cause true change. Our hope is not in ourselves or a technique but our hope is in the Lord to work through us and in your heart in order to cultivate genuine Christ-like change.

COUNSELING APPROACH

The counselor takes a Cognitive-behavioral approach from a Biblical foundation. Most of the counseling process will focus around change coming from this perspective. The related risk follows if the client does not see change from this perspective and then proceeds to move forward with counseling. It is important to note that even though we believe strongly in incorporating Scripture and prayer in the counseling session, we will not impose our beliefs on the client that does not share this same value.

CONFIDENTIALITY

We are obligated legally and ethically to keep any of the information that you share with us private and confidential. Limits to confidentiality are listed below:

- The counselor determines the client is a danger of harming himself/herself or someone else.
- The client discloses abuse or neglect of a child, elderly or disabled person.
- The client authorizes the counselor to release records.
- The counselor or counseling records are summoned or subpoenaed by a court of law.
- The counselor becomes aware of an ethical violation by another mental health professional.

APPOINTMENTS

We will make a special effort to make sure that the counseling sessions start on time. As a result, it is our expectation that you will share this expectation with us which will help start and end sessions on time. Here are a few important things to know about your appointment:

- Each appointment is typically 50 minutes long. Together, the client and counselor will make decisions concerning how often and for how long they should meet.
- In case you are running late to an appointment, please call but know that your appointment will still end at the specified time.
- In case an appointment needs to be canceled or rescheduled, please be courteous to give your counselor a 24 hour notice. Together, the client and counselor will make decisions concerning how often and for how long they should meet.
- Please make sure that all cell phones are turned off during the session to maximize the time allowed for counseling. The counselor will adhere to this policy as well.

After Hours/Emergencies

Counseling hours are Monday through Friday 8am to 6pm. In case of an emergency after hours please call your primary care physician, 911, your local hospital, or a suicide hotline: 214-828-1000 or 972-588-4007 for assistance during office hours. Please know that we will make every effort to return messages and emails the next business day for calls received after work hours or during the weekend.

Risks of Counseling

It is important for the client to know going into the session where the counselor stands in regard to the results from counseling. Although it is the full desire of the counselor to help the client and see true change, it must be understood that there are no guarantees for the client to get the results that they desire. During the counseling process, you may learn things about yourself that you do not like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from counseling. Our hope and desire is for true change to take place that gets to the heart of the issue resulting in long term change.

Ethical Guidelines

The counselor holds to a strong view of Christian ethics in and out of the counseling session. The counselor also operates under the Code of Ethics set by the American Association of Christian Counselors. A copy of the AACC code of ethics will be provided upon request.

Disputes and Complaints

The goal of counseling is to help the client bring about true change. In order to help limit disputes, please read over the policies thoroughly. The counselor will do his/her best to ensure that the correct procedures are being followed. If there is a dispute or complaint please see the counselor in a calm manner in order to bring about resolution. If further information is needed, please contact the Texas State Board of Examiners of Professional Counselors.

Fees and Charges

The current fee structure is figured on a sliding scale based on income level which ranges from $80-$120 per session. The fee is for a 50 minute session. Payment is due in full at each session and cash, personal checks or credit cards (MasterCard or Visa) are accepted. **Less than 24 hours notice results in a charge for the session.**

Between sessions, any phone calls longer than ten minutes result in additional fees. In the event that I am asked to appear in court or am subpoenaed on your behalf, my fee is $150 an hour for any preparation and from the time I leave the office until I am released by the court. I require an 8 hour retainer up front and ongoing appearances in court will result in additional retainer fees.

Consent for Counseling Services

By signing below, I have read and understand the above informed consent. I agree to abide by the contents and am willing to participate in treatment. All members of the family who are involved in the therapy need to sign below, indicating an understanding of the policies and procedures.

Client Signature: _____ Date: _____

Printed Name: _____

Counselor Signature: _____ Date: _____

Printed Name: Matt McKinney M.A., LPC

If the client is under 18, I, _____ (please print), have legal custody and give my consent for counseling of the below named minor.

Client or Guardian
Signature: _____ Date: _____

Client or Minor
Printed Name: _____

Notice of Privacy Practices
Acknowledgment of Review

I have reviewed this office's Notice of Privacy Practices as required by HIPAA (the Health Insurance Portability and Accountability Act of 1996). The privacy practices explain how my counseling information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Client or Personal Representative

_____
Date

_____
Printed Name of Client or Personal Representative

_____
Description of Personal Representative's Authority