

Please print this form, complete it and bring it with you to your scheduled appointment.

Interfaith Counseling Services, Inc.

Kathleen L. Baker, PhD

Initial Counseling Record

Date: _____

Client/Patient's Name:

Street Address:

City/State/Zip:

Phone: Home: Work: Cell:

(include area code) Fax: Email:

Where do you prefer to be contacted?

Age: Sex: M ___ F ___ Number of Dependents

(including yourself)

National Origin: Euro-American Hispanic-White Hispanic Non-White

Afro-American Asian Arab Jewish

Specify

Marital Status: Single Married Separated Divorced Widowed

Length of Marriage(s) Current Marriage

Other

Children:

Name	<input type="text"/>	Sex	<input type="text"/>	Age	<input type="text"/>	Grade	<input type="text"/>	Relationship	<input type="text"/>
Name	<input type="text"/>	Sex	<input type="text"/>	Age	<input type="text"/>	Grade	<input type="text"/>	Relationship	<input type="text"/>
Name	<input type="text"/>	Sex	<input type="text"/>	Age	<input type="text"/>	Grade	<input type="text"/>	Relationship	<input type="text"/>
Name	<input type="text"/>	Sex	<input type="text"/>	Age	<input type="text"/>	Grade	<input type="text"/>	Relationship	<input type="text"/>
Name	<input type="text"/>	Sex	<input type="text"/>	Age	<input type="text"/>	Grade	<input type="text"/>	Relationship	<input type="text"/>
Name	<input type="text"/>	Sex	<input type="text"/>	Age	<input type="text"/>	Grade	<input type="text"/>	Relationship	<input type="text"/>

Place of Employment

Address

City/State/Zip Phone

(include area code)

Type of Counseling: Marital Pre-Marital Substance Co-Dependent

Emotional Employment Social Loss of Life/Grief Parent/Child

Moral/Spiritual Re-marriage Divorce Recovery Financial

Family Relations Other _____

How did you hear about us? Word of mouth Church Radio Internet
 Print Other, please specify _____

Please check any of the following that you have seen for counseling:

Pastor Counselor Psychologist Psychiatrist Other

Who? _____ Where? _____

When? _____ How many times? _____

Reason:

Briefly discuss the condition that encouraged you to seek counseling: (Include when the condition began and other important events.)

During this period, how would you describe your response?

Guilt Grief Sorrow Despair Fear Anger Hatred Rage
 Relief Helplessness Confusion Heartache Betrayed Pity
 Don't Care Give-up Joy Loneliness Desperate Embarrassed
 Vindictive Frustration Up and Down Worthless Worried

Other

If this condition involves other persons (spouse, parents, relatives, friends, etc.) what do you think their response is?

Guilt Grief Sorrow Despair Fear Anger Hatred Rage
 Relief Helplessness Confusion Heartache Betrayed Pity
 Don't Care Give-up Joy Loneliness Desperate Embarrassed
 Vindictive Frustration Up and Down Worthless Worried

Other

Is this condition affecting other people in a negative way? (Please state who it is affecting and why it is negative)

Are there any persons who are having a negative influence on your situation?

Are there any persons who are having a positive influence on your situation?

What do you hope to accomplish by seeking counseling?

Do you know of any reason why you may not be able to accomplish your desire?

Are you currently under medication, or is there any medical condition you are experiencing now or during the past year? Please list medications.

CONSENT TO TREATMENT

You acknowledge that you desire counseling consistent with the Christian faith. You further acknowledge that no government agency regulates the principles or truths directly related to your faith as long as these principles or truths do not threaten the well being of life and/or property. You agree that if you share with the counselor anything potentially threatening, the counselor must inform these entities of the potential harm which also includes civil authorities. Finally, you completely understand that any recommendations, principles or truths are not accepted as demands. Guidance from the counselor is accepted as alternatives or other opportunities which exist, and you maintain sovereignty to make decisions free of any intrusions, religious or otherwise, on your right of determination.

The undersigned, hereby, authorizes the designated agents and employees for Interfaith Counseling Services, Inc. to provide counseling. Understanding that the treatment and recovery services at Interfaith Counseling Services, Inc. are exclusively religious in nature and are exempt by the State of Louisiana and that the programs at Interfaith Counseling Services, Inc. offers only non-medical treatment and recovery methods such as prayer, moral guidance, spiritual counseling and scriptural study.

Client/Patient's Signature _____ Date: _____

Guardian's Signature _____ Date: _____
(if applicable)

Counselor _____ Date: _____