



Date: _____

The Grove Community Church
Counseling Intake Form

Client Information:

Name (s): _____ DOB: _____

_____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Driver's License # : _____ State _____ Expiration Date _____

Place of Employment: _____

Occupation: _____ (May we call you here if necessary ?) _____

Who referred you to The Grove's Counseling Dept.? _____

Marriage and Family:

Marital Status:

Single ___ Engaged ___ Married ___ Separated ___ Divorced ___

Years Married ___ Years Divorced ___ Length of Separation ___

Spouse Name: _____ Age: ___ Occupation: _____

Mother's age: _____ If deceased, how old were you when she died? _____

Father's age: _____ If deceased, how old were you when he died? _____

If your mother and father separated, how old were you at the time? _____

If your mother and father divorced, how old were you at the time? _____

Total number of times mother divorced: _____ Total number of times father divorced: _____

I was child number _____ in a family of _____ children.

I was adopted: Yes ___ No ___

Please list children by age: (Place a check by name if from a previous marriage or adoption.)

Name	Age	Sex	Education	Living At Home	Special Concerns

Please list any other person (s) living in your home:

Name	Age	Sex	Relationship	Special Concerns



Date: _____

The Grove Community Church
Counseling Intake Form (APPENDIX E)

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Name (s): _____ DOB: _____

_____ DOB: _____

Address: _____ City _____ State _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Driver's License # : _____ State _____ Expiration Date _____

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Who referred you to The Grove's Counseling Dept.? _____

Marriage and Family:

Marital Status:

Single ___ Engaged ___ Married ___ Separated ___ Divorced ___

Years Married ___ Years Divorced ___ Length of Separation ___

Spouse Name: _____ Age: ___ Occupation: _____

Mother's age: ___ If deceased, how old were you when she died? _____

Father's age: ___ If deceased, how old were you when he died? _____

If your mother and father separated, how old were you at the time? _____

If your mother and father divorced, how old were you at the time? _____

Total number of times mother divorced: _____ Total number of times father divorced: _____

I was child number _____ in a family of _____ children.

I was adopted: Yes ___ No ___

Please list children by age: (Place a check by name if from a previous marriage or adoption.)

Name	Age	Sex	Education	Living At Home	Special Concerns

Please list any other person (s) living in your home:

Name	Age	Sex	Relationship	Special Concerns

HEALTH RATING: (APPENDIX E)

Excellent _____ Good _____ Average _____ Poor _____ Very Poor _____

Are you currently under a doctor's care? _____ If yes, please explain. _____

Physician's Name: _____ Phone:() _____

Are you currently taking medication? _____ What kind? _____

Have you ever been hospitalized before? (Ex. Surgery, Drug/Alcohol abuse, etc.) Yes _____ No _____

If yes, for what reason? _____

Name of person to call in case of an emergency: _____

Phone: _____ Relationship to client: _____

Have you, your spouse, or children, ever had any major medical or emotional problems?

If yes, please explain: _____

Have you, or any close relatives ever attempted suicide? _____

Have you ever used drugs recreationally? _____ What and When? _____

Alcohol use: Never _____ Occasionally _____ Often _____ Habitually _____

Have you received counseling before? If yes, where? _____

How long ago? _____ What type of counseling? _____

Name of counselor: _____

Have you ever received psychological testing? Yes _____ No _____

If yes, what kind? _____

RELIGION / FAITH:

Do you have a personal relationship with Jesus Christ? Yes _____ No _____

If yes, for how long? _____

Do you attend church? _____ How frequently? _____

Are there any recent changes in your faith or church attendance? _____ Please explain _____

SPECIFIC PROBLEM AREAS: Please check any of the following that are currently troubling you:

- | | | | |
|------------------------------------------------|------------------------------------------|-------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Abortion/Adoption | <input type="checkbox"/> Depression | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Divorce | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Religion/Faith Issues |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Envy/Jealousy | <input type="checkbox"/> Loss of Control | <input type="checkbox"/> Sexual Abuse/Rape |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Family Issues | <input type="checkbox"/> Loss of Concentration | <input type="checkbox"/> Sexual Issues/Addiction |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Fear | <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Singleness |
| <input type="checkbox"/> Bitterness/Resentment | <input type="checkbox"/> Finances//Debt | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Single Parent |
| <input type="checkbox"/> Burnout/Stress | <input type="checkbox"/> Forgiveness | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Spouse Abuse |
| <input type="checkbox"/> Change of Lifestyle | <input type="checkbox"/> Frustration | <input type="checkbox"/> Loss of Temper | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Guilt | <input type="checkbox"/> Loss of Trust | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Children/Discipline | <input type="checkbox"/> Health/Medical | <input type="checkbox"/> Marriage | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Children/School | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Medication/Drug Issues | <input type="checkbox"/> Rejection |
| <input type="checkbox"/> Children/Rebellion | <input type="checkbox"/> Honesty | <input type="checkbox"/> Mid-Life | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Infidelity | <input type="checkbox"/> Mother Issues | <input type="checkbox"/> Violence/Rage |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> In-Laws | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Crisis/Conflict | <input type="checkbox"/> Job Problems | <input type="checkbox"/> Parenting | <input type="checkbox"/> Worry |
| <input type="checkbox"/> Death of Loved One | | | |

Signature: _____

The Grove Community Church Counseling Department

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your “Protected Health Information” (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted by required law. It also describes your rights to access and control your protected health information. “PHI” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the Counseling Department’s practice, and any other use required by law.

- **Treatment**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

- **Payment**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- **Healthcare Operations**

We may use or disclose, as needed, your protected health information in order to support the business activities of the Counseling Department’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of student therapists, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to student therapists that see patients at our office. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: *as required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirement, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker’s Compensation, Inmates, required uses and disclosures, under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.*

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except, to the extent that your therapist or the Counseling Department’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

- **You have the right to inspect and copy your protected health information,**
Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in the reasonable anticipation of, or use in civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information.**
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to which you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternate location.**
You have the right to obtain a paper copy of this notice alternatively, i.e., electronically.
- **You may have the right to have your therapist amend your protected health information.**
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate** against you for filing a complaint.

This notice was published and becomes effective on/or before **June 15, 2004**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

HIPPA (Health Insurance Portability and Accountability Act of 1996)

I, _____
Please print name of client

I, _____
Please print name of spouse

I, _____
Please print name of minor, then sign below as parent/guardian

acknowledge receipt of the Notice of Privacy Practices.

The Grove Community Church
Counseling Center
19900 Grove Community Drive
Riverside, CA 92508

Client's signature: _____

Spouse's signature: _____

Parent/Guardian/Conservator's Signature: _____

Note: Parents must have legal custody. Legal guardians and conservators must show proof.

Name of Counselor: _____
Please print

Counselor's Signature: _____

Date: _____

Client Agreement

We appreciate your interest in seeking assistance from The Grove Community Church Counseling Center. Our Counseling Department is staffed by a licensed Marriage and Family Therapist (M.F.T.), M.F.T. Interns, M.F.T. Trainees in the final year of their graduate program in Marriage and Family Therapy who are supervised by licensed clinicians on staff, and Pastoral Counselors. We believe that a clear understanding of the practical aspects of your relationship with us, at the onset of treatment, is in the best interests of counseling. It is with this in mind that we present the following information to you:

1. **Counseling** – Consists of face-to-face contacts between a staff member and the person or persons in treatment. The type of treatment will be decided between you and your counselor and may include referrals for additional psychological and/or medical services. You are expected to benefit from your participation in counseling, but you may feel temporarily worse while in treatment. Neither the counselor, his or her supervisor, nor The Grove Community Church, accepts responsibility for the outcome of your counseling.
2. **Sessions** – Appointments will be scheduled through the Counseling Secretary unless otherwise arranged. Sessions are approximately 50 minutes in length and cost \$40 for appointments before 5 p.m. Monday through Friday, \$50 for appointments after 5 p.m. Monday through Thursday, and \$50 for weekend appointments. A sliding scale may be implemented per an agreement with Pastor Ronveaux if payment is difficult. If you are unable to attend your session we ask that you notify the Counseling Secretary a minimum of 24 hours in advance by calling (951) 571-9090 Ext. 2221 to cancel or reschedule. **Effective May 1, 2007, cancellations of less than 24 hours or no shows will be charged \$40 for appointments before 5 p.m. Monday through Friday, \$50 for appointments after 5 p.m. Monday through Thursday, and \$50 for weekend appointments. Effective January 1, 2007, Voting Members of The Grove Community Church receive one free session; however, a no show or cancellation of less than 24 hours will automatically waive the free session.**
3. **Psychological Testing** – In many cases, the use of psychological tests is a useful tool in shaping the treatment. The psychological tests given at The Grove Community Church are standard and need to be completed as soon as possible.
4. **Emergencies** – If an emergency occurs during business hours (8 a.m. to 5 p.m.), call (951) 571-9090 Ext. 2221, and your counselor will contact you as soon as possible. If an emergency occurs during non-business hours, please *call 911* or the following **24-hour crisis hotline number: 686-4357.**
5. **Confidentiality Rights** – We comply with the Confidentiality of Medical Information Act where applicable and other applicable laws. All information shared by you with your counselor is kept confidential except in the following situations:
 - a. If there is reasonable cause to believe that you are in such a mental or emotional condition as to be dangerous to yourself or to the person or property of another, or
 - b. If you reveal any act of abuse against a child (under 18 years old) or an elderly person, or
 - c. If you sign a written release of information allowing for specific information to be provided to or exchanged with professionals or others involved in your treatment, or
 - d. Because this is a training site for counselors, consultation with Pastor Ronveaux (MFC 37034), Hilary Catling (MFC 39694), or Ahna Mink (MFC 40043) will occur in order to increase the quality of service provided to you. If deemed necessary Senior Pastor Tom Lance will be consulted as well.
6. **Voting Members of The Grove Community Church** will receive one counseling session at no charge (see #2 above).
7. **Community Services Fees** – The Counseling Center also offers counseling services to the greater Riverside community, provided by trainees, interns, or fully-licensed clinicians. Charges for counseling are \$40 per session for appointments before 5 p.m. Monday through Friday, \$50 per session for appointments after 5 p.m. Monday through Thursday, and \$50 for weekend appointments. A sliding scale may be implemented per an agreement with Pastor Ronveaux if payment is difficult. There is no charge for pastoral counseling; however, a referral may be made to a trained professional who would require a fee.

We hope your involvement with us will be helpful and profitable to you. If you have any questions regarding these arrangements or other aspects of your relationship with us, please feel free to discuss them with your counselor.

By signing below, I acknowledge that I have read and understood the Client Agreement outlined above.

Client Name (please print) _____

Client Signature _____ Date _____

Client Name (please print) _____

Client Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Counselor/Pastor Signature _____ Date _____