E91 COUNSELING MINISTRY

Applicant Profile

Personal Information

Last Name: _____ First Name: _____ Middle Name: _____

What is your preferred name? _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Date of Birth (MM/DD/YY): _____ Age: _____ Sex: Male _____ Female _____

Race (optional): _____ National Origin (optional): _____

Please list phone numbers where the counselor may contact you:

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

Military Branch of Service (if applicable) _____

Emergency Contact Information

Who should E91 Counseling Ministry contact in the event of an emergency involving you?

Name: _____ Phone Number: ( ) _____

Relationship to you: _____ May we leave a message? _____

Counseling Information

In your estimation, what is your greatest concern or need?

_____

_____

_____

_____

Please estimate the severity of your problem by placing an "X" on the line below:

_____

Mildly Upsetting	Moderately Severe	Severe	Extremely Severe	Totally Debilitating

Were you referred to E91 Counseling? Yes ___ No ___ If yes, by whom? _____

Have you been treated by, consulted with, or received counseling/therapy from a mental health professional in the past? Yes ___ No ___

Are you currently under the care of a mental health professional? Yes ___ No ___

Have you been treated by, consulted with, or received counseling/therapy from a mental health professional at E91 Counseling (fka Crucible Counseling) in the past? Yes ___ No ___

If yes, who was your counselor? _____

Health Information

Please list any previous therapy or treatment you have received from mental health professionals:

Date(s)	Name of Therapist / Place of Therapy	Nature of Problem / Reason for Seeking Therapy	Result of Treatment

How would you describe your general health condition? Excellent ___ Good ___ Fair ___ Poor ___

Describe and date any serious illnesses, accidents, or operations you have had:

_____

_____

_____

Date of your last physician visit? _____ What was the purpose of this visit? _____

Please list any medications you are currently taking:

Name	Dosage / Frequency	Results

Mark ("X") any of the following that apply to you:

___ palpitations
___ headaches
___ anger
___ nightmares
___ tense
___ depressed
___ unable to relax
___ concentration difficulties
___ can't make friends
___ financial problems
___ bowel disturbances
___ can't keep a job
___ alcoholism
___ dizziness
___ stomach trouble
___ fatigue
___ take sedatives
___ feel panicky
___ conflict
___ suicidal thoughts
___ sexual problems
___ over-ambitions
___ memory problems
___ lonely
___ inferiority feeling
___ tremors
___ fainting spells
___ anxiety
___ no appetite
___ insomnia
___ don't like weekends or vacations
___ take drugs
___ allergies
___ shy with people
___ can't make a decision
___ unable to have a good time
___ military service
___ home conditions bad
___ recent death of family/friend
___ children leaving home
___ employment change
___ frequent over-eating

Family Information

Marital Status: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed ___

Name of spouse/roommate: _____ Male ___ Female ___ Age _____

Please complete the following information about your children (if applicable):

Name	M/F	Age	Live with you?	Briefly describe your relationship with your child.

Church Information

Do you attend East 91st Street Christian Church? Yes ___ No ___ If yes, how often? _____

Are you a member of E91? Yes ___ No ___

Do you attend another church? Yes ___ No ___ Name of that church? _____

Personal Spiritual Information

Do you trust Jesus Christ as your personal Savior? Yes ___ No ___

If yes, please briefly describe how you came to that decision. _____

_____

_____

Have you been baptized? Yes ___ No ___ If yes, by immersion? Yes ___ No ___ Unsure ___

Are you involved in a small group? Yes ___ No ___ If yes, which one(s)? _____

Are you serving in an area of ministry? Yes ___ No ___ Ministry Name: _____

Significant Life Events

Please answer the following questions:

Are you currently having thoughts of harming yourself (e.g. cutting or suicide)? Yes ___ No ___

If yes, please explain: _____

Have you ever attempted suicide? Yes ___ No ___

If yes, when: _____

Please describe the circumstances: _____

_____

Have you ever engaged in self-harm behavior (e.g. cutting, burning)? Yes ___ No ___

If yes, when: _____

Please describe the circumstances: _____

_____

Have you ever been physically or sexually abused? Yes ___ No ___

If yes, what was your relationship to the abuser? _____

Are you currently or in the past have you used a controlled substance or alcohol? Yes ___ No ___

If yes, please describe: _____

Does any member of your family suffer from addictions or substance abuse? Yes ___ No ___

If yes, what is their relationship to you? _____

Has anyone in your family been hospitalized for psychiatric care? Yes ___ No ___

If yes, what is their relationship to you? _____

Do you or does anyone in your family struggle with the following behaviors: pornography, Yes ___ No ___

gambling, shopping, hoarding, etc. If yes, what? _____

Printed Name of Client	Signature of Client	Date

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E91 Counseling Ministry

Located at East 91st Street Christian Church

CHILD INTAKE FORM

(Form to be completed by parent, legal guardian, or custodial parent of child)

Date:_____

I. Child Information

Child Personal Information

Last Name: _____ First Name:_____ Middle Name:_____

What is the child's preferred name? _____ Birth date:_____

Does the child have siblings? □ Yes □ No If yes, how many? _____

Please provide the following information about the child's siblings (if any):

Name(s): _____ Date of Birth: □ Male □ Female

_____ Date of Birth: □ Male □ Female

_____ Date of Birth: □ Male □ Female

With whom does the child currently reside?_____

What is the name of the child's school? _____

In what grade is the child currently registered? _____

Please provide a brief description of the child's extracurricular activities and interests:

_____

_____

Child Medical History

How would you rate your child's current physical health? □Excellent □Good □Fair □Poor

Is your child currently complaining of any physical problems (e.g. headaches, stomach aches)?

□Yes □No If yes, please explain:

_____

Has your child ever been hospitalized for medical reasons? □Yes □No
If yes, please provide the following information:

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Please list your child's chronic medical conditions or disabilities, if any:

_____

Please list your child's learning disabilities, if any:

_____

Please list the medications that your child is currently taking, if any:

MEDICATION(S) Over-the-counter or prescription	DOSAGE

Child Mental Health History

Has your child previously been treated by, consulted with, or received counseling/therapy from a mental health professional? ☐Yes ☐No If yes, when? _____

Is your child currently under the care of a mental health professional? ☐Yes ☐No

If yes, what is that professional's name?_____

What prompted the child's previous visitation to a mental health professional?

_____

Has the child ever been diagnosed with or treated for any type of mental illness? ☐Yes ☐No

If yes, what was the diagnosis? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness?

☐Yes ☐No If yes, what was the diagnosis? _____

Reasons for Seeking Help

What concerns about the child have brought you to seek our counseling services?

_____

_____

Where are these concerns causing the most problems for YOU? Please check all that apply:

☐Home ☐Work ☐Marriage ☐Other: _____

Where are these concerns causing the most problems for your CHILD? Please check all that apply:

☐Home ☐School ☐Friends ☐Other: _____

When did the present concerns begin to be a problem for your child?

_____

_____

Have others (besides family members) identified concerns regarding your child? ☐Yes ☐No

If yes, please briefly describe the nature of these concerns:

_____

Please indicate which of the following problems the child experiences. Check all that apply:

☐Crying spells

☐Excessive fears or anxieties

☐Difficulty being away from specific family members

☐Hearing voices

☐Getting into trouble at school/play

☐Temper tantrums

☐Difficulty falling asleep/inability to sleep at night

☐Decreased/increased appetite

☐Loss of interest in usual activities family members

☐Hyperactivity

☐Bullying/picking fights

☐Refusal to respond to authority

☐Nightmares

☐Obsessions/compulsion with specific activities

☐Lack of motivation

☐Lack of self-confidence

☐Difficulty making or keeping friends

☐Other: _____

II. Parent Information

Parent/ Guardian Personal Information

Last Name: _____ First Name:_____ Middle Name:_____

What is your preferred name? _____

Address: _____ Apartment #_____

City:_____ State:_____ Zip:_____

Phone (Day#): _____ (Evening #):_____ (Cell #):_____

Pager:_____ E-mail address:_____

May we leave a message on your telephone? ☐Yes ☐No If yes, on which number(s)?_____

May we mail counseling information to your home? □Yes □No

May we send counseling information to your e-mail address? □Yes □No

What is the highest level of education that you have achieved? _____

Do you work? □Yes □No If yes, what is your occupation?_____

Parent/ Guardian Relationship Information

What is your current marital status? □Single □Married □Separated □Divorced □Widowed

Have you ever been married? □Yes □No If yes, how many marriages have you had? _____

Have you ever been divorced? □Yes □No If yes, when? _____

Have you ever been separated? □Yes □No If yes, when? _____

If you are separated or divorced:

Do you have at least partial custody of your child(ren)? □Yes □No

If yes, what percentage of the time does your child(ren) reside with you? _____

With whom does your child(ren) reside when they are not with you?_____

Do you have legal authority to seek counseling for your child? □Yes □No

Are you legally required to have consent from another custodial parent prior to seeking counseling for your child? □Yes □No

****NOTE**: If you are not required to obtain the consent of another custodial parent, you still must present a copy of the divorce decree to E91 Counseling before counseling can begin.

Parent/ Guardian Personal Spiritual Information

Do you believe in God? □Yes □No

Are you a Christian? □Yes □No

If not, how would you describe your religious beliefs? _____

Please describe the significance of faith in your life? _____

How much influence does your religion/ faith have on your day-to-day activity?

□ A lot □ A moderate amount □ A little □ None

Has your faith changed recently? □Yes □No If yes, describe how:_____

_____

If you are married, what is the religious background and belief of your spouse?_____

_____

Do you and your spouse agree on religious issues? □Yes □No

If no, describe your differences:_____

_____

Are you a member of a church? □Yes □No If yes, which one? _____

Emergency Contact Information

Who should E91 Counseling contact in the event of an emergency involving your child?

_____

What is his/her relationship to the child? _____

What is his/her telephone number? _____

Counseling Information

What do you hope to gain from bringing your child to receive counseling?

_____

_____

How did you hear about our counseling ministry? □Friend □Church □Pastor □Other: _____

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

E91 Counseling Ministry

Located at East 91st Street Christian Church

CONSENT FOR COUNSELING MINORS

Name of Parent/Guardian_____

Name of Minor Recipient of Counseling Services ("Minor" or "Child")_____

Minor's Date of Birth _____

Are you the parent of this Child? □Yes □No

Are you currently married to the Child's other parent? □Yes □No

Are you divorced? □Yes □No If yes, are you the custodial parent of the Child? □Yes □No
If yes, please provide E91 Counseling with a copy of the divorce decree.

Are you the legal guardian of the Child? □Yes □No If yes, please provide E91 Counseling with a copy of the guardianship form.
**If you are not the legal guardian, it is the understanding that both legal guardians have approved this treatment. If this is not the case and one legal guardian does not approve of treatment, counseling will be stopped immediately.

* * * *

By signature below, I certify that I authorize and give permission to E91 Counseling to provide counseling services to my child.

I understand that counseling services may include individual or family psychotherapy, counseling, and testing. I also understand such counseling services may include consultations with other members of the staff of East 91st Street Christian Church and also may include referrals to other appropriate professional, county, or state agencies, where necessary.

_____

Signature of Parent/Guardian/Custodial Parent Date

_____

Signature of Parent/Guardian/ Custodial Parent Date

Street Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Emergency Contact (Other than yourself):

Name _____ Phone _____

_____

Signature of Witness/Title **Date**

E91 Counseling Ministry

Located at East 91st Street Christian Church

COUNSELING/COACHING RELATIONSHIP INFORMED CONSENT

MISSION STATEMENT:

E91 Counseling Ministry is a place to promote, for those who are willing, the continuous journey to be transformed into the image of Christ.

E91 Counseling Ministry exists to honor God by serving our local community, other area congregations, and the Kingdom worldwide. We accomplish this through two distinct avenues.

- Provide affordable biblical counseling and coaching services to individuals and families that are struggling with a variety of issues and wish to see God transform their lives while integrating faith into the healing process.
- Trains and mentors masters and postgraduate level counseling and practical ministry students. Our facility provides internship and residency opportunities designed to develop the next generation of solid, professional, biblical counselors and ministry leaders.

Our goal for these professionals is to influence the far corners of the world for Christ through various churches, mission organizations, and Christian counseling practices.

"Do not conform any longer to the pattern of this world but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is, his good, pleasing and perfect will" (Romans 12:2, NIV).

Would you like a copy of the E91 Counseling Ministry Scope of Practice? ____Yes ____No _____ **Initials**

COUNSELING SERVICES:

E91 Counseling is located at East 91st Street Christian Church offers its services at a reduced cost. E91 Counseling does charge a $25 fee for an initial appointment. Initial appointment counselors typically meet with you for one session to gain an understanding of your situation and to identify resources, both within the church and out in the community that may be helpful in resolving your difficulties and fostering spiritual growth. Beyond the initial appointment, a sliding fee scale is used for most services and is set forth on a separate Financial Agreement which you will be given at the time of the initial appointment. When available, E91 Counseling provides a limited amount of short-term counseling sessions with graduate interns, which typically involves eight to twelve 50-minute sessions. We treat individuals 12 and over. If it is determined that long-term counseling would be more beneficial, we may also assist you in connecting with an onsite Resident Counselor or in finding a local professional Christian therapist in the community. As a training facility, E91 Counseling does not provide diagnoses, diagnostic impressions, or disorder-related codes. If appropriate and available, E91 Counseling provides coaching services using certified professional coaches.

If your counselor or coach ("service provider") attempts to communicate with you and is unsuccessful, ***a letter will be mailed to the address you've provided if you have an outstanding balance***. If no communication is made within 35 business days, your file will be closed and retained for the minimum amount of years the law requires. _____ **Initials**

COMMUNICATION:

_____ **Initials**

Service providers will communicate with client via cell phone, office phone, or postal mail only. Service providers will not communicate with clients via email, text messaging, or social media. If a client contacts a service provider using any of the previous avenues, the service provider will not respond. Service providers will check their messages and will return calls within 24 business hours. Service providers will not conduct sessions via phone or computer. Phone calls may be used to schedule, provide a risk assessment and/or provide recommendations or referrals. I agree to allow E91 Counseling Ministry to leave a voicemail on this designated phone number: _____.

CLIENT RIGHTS:

1. To have the service provider available at the appointment time agreed upon in advance.
2. To understand any issue related to treatment, the therapy process, or the coaching process.
3. To ask questions about your service provider, his or her methods, and/or the direction the counseling or coaching is headed.
4. To discontinue counseling or coaching at any time. Should you decide to discontinue, your service provider may request a termination session to discuss progress or areas of continuing concern.
5. To request a change of service provider. If you should feel the need to change service providers, feel free to discuss that issue with your present service provider.
6. To request a copy of your records. E91 Counseling does charge a $25.00 fee for each copy. Payment is due when you pick up the copy of your records.
7. In the event of provider death, incapacitation, or sudden departure from E91 Counseling Ministry, client will have the option of being transferred to another provider at E91 Counseling Ministry, when available, or being referred to another therapist in the community.

CLIENT RESPONSIBILITIES:

1. To arrive for counseling/coaching sessions on time, so that the hour (50 minutes) set aside can be utilized maximally.
2. To bring your contracted payment for counseling/coaching sessions in the form of cash or check (written to East 91st Street Christian Church) and to give that to your service provider at the beginning of each session.
3. To cancel appointments 24 hours in advance, see below.
4. Cooperate with your service provider in treatment planning and process. Counselors and coaches do not possess the ability to change your life or fix your problems. Resolution will only come through consistent effort on your part in conjunction with your actively seeking and inviting Christ into your life and into the healing process.
5. Please do not offer the service providers any type of gift.
6. If you have a counseling emergency and are unable to reach your counselor in training or resident counselor, please contact one of the following resources for immediate assistance:
   - Crisis Intervention/Connect2Help (24 hours): 251-7575.
   - St. Vincent, St. Francis and Community North Hospitals: 24 hour emergency counseling care, available through their emergency rooms.

CANCELLATION OF AN APPOINTMENT:

_____ Initials

When you schedule your appointment, you have reserved this time in our schedule and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 317-598-1580 and press 3 ***at least 24 hours in advance***—if no one is available to take your call, please leave a voice mail message.

Late Cancellations and No Show Policy:

E91 Counseling Ministry will charge for each appointment that is missed without adequate notice ("no show"). A no show is an appointment that is:

- missed without notice
- missed with less than one day's (24 hour) notice
- missed due to arriving 15 minutes or more beyond the scheduled appointment time

If you no show 3 times in a consecutive 12 month period, you may be discharged from the center.

If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits, you will be charged for the full price of the session. Exceptions to this policy can be made at the discretion of the therapist and Supervisor.

You will be billed directly for missed appointments. Payment for missed appointments is due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay the outstanding balance at the time you check in for your next appointment.

LIMITS OF CONFIDENTIALITY:

_____ **Initials**

1. The results of treatment or tests must be revealed to a court when a client has been ordered into treatment by the court.
2. A service provider may take steps to protect a client or others from imminent danger, when a client threatens physical injury to self or others.
3. A service provider must report disclosures of physical or sexual abuse of a minor to the local children's protective service. A service provider must also report abuse, neglect or domestic violence for endangered adults.
4. Counselors in training consult with supervisors and with fellow students in a structured classroom setting and in individual supervision about clients' progress. All supervisors hold a master's degree in a field of counseling and are licensed by the state of Indiana as Mental Health Counselors, Marriage and Family Therapists, or Clinical Addiction Counselors.
5. E91 Counseling provides reduced cost counseling and coaching under the ministry umbrella. Service providers working for E91 Counseling are not available to give testimony in legal matters.
6. With my consent, E91 Counseling may use and disclose protected health information about me to carry out treatment, payment, and mental healthcare operations.
7. Indiana requires a mental health provider to warn third parties if a mental health client that has been diagnosed with HIV/AIDS has expressed intention to harm an identifiable victim.
8. If client has consented to limited disclosure of counseling or coaching records to specific professionals, agencies, and individuals, E91 Counseling and/or service provider is not liable for any re-release of information from the consented party.
9. In response to a complaint filed by the client against the service provider, counseling or coaching records can be released and viewed by individuals and entities outside of E91 Counseling Ministry.

TESTIMONY ACKNOWLEDGEMENT:

_____ **Initials**

I understand that E91 Counseling Ministry is an internship/resident site for counselors in training who are not trained to provide testimony in legal matters.

- I understand that in order for E91 Counseling to continue its ministry effectively, it must limit the services that it provides to services that will further its charitable, religious, and educational purposes.

- Acknowledging the above, I understand that it is not the intent of E91 Counseling Ministry, its pastoral counselors, staff, contracted service providers, or its residents/interns to assist Clients by providing legal testimony, otherwise participating in legal matters, or providing any other services that will not further the charitable, religious, and educational purposes of E91 Counseling. I agree that I will not request E91 Counseling, its pastoral counselors, staff, contracted service providers, or its residents/interns to provide such services for me in legal matters.

SUPPORT PLAN:

_____ **Initials**

By signature on this document entitled "Counseling/Coaching Relationship Informed Consent," and in exchange for my receiving counseling or coaching services through E91 Counseling Ministry, **I agree not to harm myself, attempt to harm myself, or harm anyone else while in treatment at E91 Counseling.**

If my circumstances change and I do feel that I might harm myself, I will contact the following:

a) I will call _____ (support person) at _____ (phone number).

b) I will call the Crisis Intervention Hotline (24 hours) at 317-251-7575

c) I will dial 911 for emergency assistance or go directly to a hospital emergency room. I know that St. Vincent, St. Francis, and Community North Hospitals all offer 24 hour emergency counseling care at their respective emergency rooms.

AUDIO/VIDEO RECORDING AND SECURITY:

_____ **Initials**

For the security of providers and clients, the counseling center is under audio/video surveillance. I understand that all interactions and sessions that occur within the counseling center, including the waiting room, are recorded. I further understand that all audio/video recordings are stored in a secure manner, recordings are only accessible by authorized individuals, and that such recordings will be erased, rerecorded, or destroyed after a reasonable period of time.

By my initials here _____ and my signature below, I hereby authorize my provider at E91 Counseling to view the audio/video recording of my session(s) for educational and training purposes and for the benefit of my treatment. I understand the audio/video recording(s) will be viewed by the service provider and/or the service provider's supervisor(s) in individual or group supervision settings at E91 Counseling and/or the graduate school in which a service provider is enrolled.

AGREEMENT WITH E91 COUNSELING MINISTRY:

I (We) understand that the E91 Counseling Ministry staff, interns, residents, coaches, contracted service providers, and/or volunteers will attempt to assist me (us) in developing a plan, and that they do not make any representations or warranties with respect to the results of their services and/or referrals or their ability to help me (us) with my (our) credit/financial/emotional management. I (We) understand that our E91 Counseling Ministry staff, interns, residents, coaches, and contracted service providers consult with supervisors and with fellow students in a structured classroom setting and in individual supervision about my (our) progress. I (We) understand that E91 Counseling is under ongoing audio/video surveillance for security and training purposes. I (We) understand that E91 Counseling Ministry staff, interns, residents, coaches, and contracted service providers do not provide diagnoses, diagnostic impressions, or disorder-related codes. I (We) further understand that the E91 Counseling Ministry staff, interns, residents, coaches, contracted service providers and/or volunteers are not available to and will not give testimony in legal matters. Should my (our) interactions with E91 Counseling Ministry require the E91 Counseling Ministry staff, supervisors, interns, residents, coaches, contracted service providers, and/or volunteers to incur legal expenses in conjunction with my (our) counseling/coaching and related matters, including all and excluding none, I (we) understand I (we) will be required to pay for all costs and expenses associated therewith. I (We) understand if successful treatment is beyond the scope of E91 Counseling Ministry's scope of services, I (we) may be referred to another, more comprehensive facility which is better equipped to respond to my needs. I (We) understand and consent that upon the need for an internal transfer from one service provider to another within E91 Counseling Ministry, my (our) file will be transferred as well. I (We) further understand and acknowledge that East 91st Street Christian Church, staff, interns, residents, coaches, contracted service providers, and/or volunteers would not allow the undersigned to participate in these services without releasing and holding harmless the Church. The undersigned further acknowledges that this is a full and complete release for all injuries and damages, which the undersigned may sustain as a result of the undersigned's participation in these services.

Client: _____ _____

Print name ***Signature***

Counselor: _____ Date: _____

(Signature)

E91 Counseling Ministry

Located at East 91st Street Christian Church

Financial Agreement

E91 Counseling Ministry charges all clients an initial counseling appointment fee of $25. Beyond the initial appointment, E91 Counseling determines appropriate fees based on provider availability and a sliding fee scale for most services. EMDR utilizes a separate fee structure.

Please list your total gross annual household income: _____

E91 Counseling Ministry Expectations

The following are the expectations of E91 Counseling with respect to the counseling and coaching services provided by E91 Counseling to you:

- Payment of the fee identified is expected at the beginning of each session. The Center accepts **check or cash only**. **Please make all checks payable to East 91st Street Christian Church. There is a $30 fee for all returned checks.**
- If you need to cancel an appointment, you must give your counselor or coach **a minimum notice of 24 hours**. Missed appointments with less than 24 hours of notice will be billed as per the Counseling Relationship Informed Consent.
- If you encounter financial difficulties at any time during your counseling or coaching experience, please discuss this circumstance with your counselor/coach.

By signature below, I confirm that I have read, understand, acknowledge, and, where applicable, agree to satisfy the expectations, and to undertake the payment obligations identified in this document entitled "Financial Agreement."

_____ _____

Signature of Client Signature of Client

_____ _____

Printed name of Client Printed name of Client

Date _____ Date _____

FOR OFFICE USE ONLY:

Client Payment Obligation, sliding scale rate per session (intern/resident rate or EMDR rate): _____

Adjusted hourly fee (to be completed by the Center): $_____ **Approved:** _____ (Supervisor's initials)

Client Signature for adjusted rate _____ Date_____

Forms Requirements:

Applicant Profile
- Each adult (age 18 and over) that will attend family counseling should complete and sign an Applicant Profile. One form for each adult.

Child Intake Form & Consent For Counseling Minors
- For each minor (under age 18) that will attend family counseling, a parent/guardian should complete and sign a Child Intake Form and a Consent For Counseling Minors. One set of forms per minor child.

Counseling/Coaching Relationship Informed Consent
- Each adult (age 18 and over) that will attend family counseling should complete a Counseling Relationship Informed Consent. One form for each adult.
- Each minor (under age 18) that will attend counseling should sign/date below the parent/guardian signature on the Counseling/Coaching Relationship Informed Consent.

Financial Agreement
- One form should be completed for the family and signed by the parent(s)/guardian(s) attending family counseling. One form per family.

Note: Only the Parent(s)/Guardian(s) should attend the Initial Appointment. ***Minor children should NOT attend the Initial Appointment.*** If all participants are 18 and older, all individuals that will attend family counseling must attend the Initial Appointment.