A Ministry of

The Kentucky Avenue Church of Christ

MENTAL HEALTH COACHES

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New Beginnings Mental Health Coaching
470 Kentucky Avenue | Woodland, CA 95695
(530) 661-7488

CONFIDENTIAL
Personal Information

Please provide the following information. Information you provide is confidential just as therapy. Please print out this form and bring it to your first session or allow yourself 15 minutes prior to your appointment to complete the form in the office.

Date: _____

Name: _____
(First) (Last) (Middle Initial)

Name of parent/guardian (if you are a minor):

_____
(First) (Last) (Middle Initial)

Birth Date: _____ /_____ /_____ **Age:** _____ **Gender:** □ Male □ Female

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please be aware that email might not be confidential.

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

If married, name of spouse: _____

Name of Children and ages:_____

Referred by: (check any that apply)
□Internet Search □Family or Friend □Church Website □Another Mental Health Coach or counselor:

Cost is based upon a sliding scale Highest fee is $45.00 Lowest is $20.00

Annual Gross Income	Amount
25,000-29,000	$45.00
20,000- 24,999	$35.00
15,000-19,000	$30.00
10,000-14,999	$25.00
10,000 and under	$20.00

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Client Intake Form (Part 1)

1. Who in the family is coming in for coaching or counseling? Self____Other_____
   Name:_____

Any prior coaching or counseling? Yes_____ No_____ If yes, when, and where_____ with whom? _____

for what purpose?_____

_____

_____

2. Person to contact in case of an emergency (Name, address, phone, relationship):

_____

_____

3. In your own words, briefly state the nature of your concern:_____

_____

_____

4. What is your most difficult relationship right now?_____

_____

_____

5. What is your most difficult emotion right now?_____
6. CRISIS INFORMATION: Any current suicidal thoughts or feelings, or actions?
   If yes, please explain_____

_____

7. Any homicidal or assaultive thoughts or feelings, or anger control problems? _____Yes
   _____No If yes, please explain_____

_____

8. Any past problems, hospitalizations including incarceration for suicidal or assaultive behaviors? _____ Yes No_____ If yes, please explain_____

_____

9. Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)?

_____ Yes _____No If yes, please explain_____

_____

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Client Intake Form (Part 2)

1. Are you presently taking any medication(s)? ____ Yes _____No
   If so, what?_____

_____

Any problems with: ____ Eating ____sleeping _____pain _____ recent weight changes_____

2. Any other medical problems? _____

_____

3. Have you or a family member ever been hospitalized for a mental or emotional illness? _____Yes _____No if yes, please explain dates, place, reason:

_____
_____
_____
_____
_____
_____
_____

Common problems/ symptom checklist: 0= None,1= Mild, 2= Moderate, 3= severe

_____ marriage	_____ divorce/separation	_____alcohol/drugs	_____God/faith
_____ premarital	_____ child custody	_____ other addictions	_____ Church/ministry
_____ singleness	_____ disabled	_____ grief/loss	_____ past hurts
_____ sexual issues	_____ work/ career	_____ depression	_____ codependency
_____ family	_____ school/ learning	_____ fear/anxiety	_____ intimacy
_____ Children	_____ Money/budgeting	_____ anger control	_____ communication
_____ parents	_____ aging/ dependency	_____ loneliness	_____ self-esteem
_____ in-laws	_____ weight control	_____ mood swings	_____ stress management

Other (specify):_____

_____

_____

Client _____ Date_____

Witness _____ Date_____

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CLIENT INTAKE FORM- PERSONAL INFORMATION

Today's Date _____

Client Name_____ **Nickname**_____

Address_____ **Age**_____ **D.O.B.**_____

Email_____

Home Phone_____ **(work)**_____ **Ext#**_____
Cell_____

Client Occupation _____ **#of years at this occupation**_____

Check Marital Status _____**Single** _____**Engaged** _____**Married** (how long)____,_____
Separated (how long)_____, _____ **Live-in mate**_____

Parent/Guardian Name/ address/ phone_____

(for children only) _____

Partner's Information (Optional)

Partner's Name _____ Nickname_____

Address (if different from yours) _____

Age_____ **D.O.B.** _____

Home Phone_____ **(work)** _____ **Ext#**_____
Cell _____

Client's occupation_____ **#of years at this occupation**_____

List name, age, birthdate, sex and relationship of all children, and/or siblings, including foster children, and/or children of mate, or roommate and whether they live at home with you.

Name	Age	Birth Date	Sex	Relationship
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____
_____	_____	_____	____	_____

In the State of California: _____ practices Christian Mental Health Coaching and/or counseling in accordance with section 2908 of the State of California Business and Professional code, and does not provide services under the laws regulating licensed Marriage and Family Counselors, Clinical social workers, and Psychologists, Licensed Professional Clinical Counselors in the State of California. California has no provision to license Pastoral/Christian counselors.

I understand this is a faith-based, Mental Health Coaching/Christian Counseling service. _____ is a Board Certified Christian Mental Health Coach/Counselor, not a psychologist, and as such, will **NOT** testify in any litigation. In the unlikely event of a subpoena, "The Mental Health Coach or Counselor" will exercise his/her right to fully invoke the clergy/client confidentiality privilege for the sole purpose of protecting his position as clergy and the sacred trust of those he counsels.

I understand no guarantees of any kind have been represented to me by "the Mental Health Coach or Counselor", as to my personal experiences, or the possible results of this session. I agree and understand payment for professional services is required at time of visit, and that this office will not bill in lieu of payment. I will pay any legal or collection fees related to nonpayment of my bill, including worthless check charges. I accept full responsibility for charges for myself, my dependent children, or "Client" named above". I understand any threats of imminent harm to self, or others, including but not limited to, child molestation/abuse, and/or elder molestation/abuse, must be reported by_____ to the proper authorities.

I understand there is a **MANDATORY 24hr. cancellation policy** that states I am liable for reserves appointment time fees/cost in full, prior to next appointment.
I release all liability, in any form, that may be charged against "the Mental Health Coach, by myself, or my estate, for actions concerning these sessions and, _____ shall not be liable for any damages or injury arising out of the sessions.
_____ disclaims any and all liability for direct, indirect, incidental, consequential, punitive, and special or other damages, lost opportunities, lost profit or any other loss or damages of any kind. I enter into this agreement of a sound mind, without any influence of drugs, alcohol or duress.

My signature below testifies that I have read, and do understand, the entire contents of this Intake form, and have reviewed the same with _____, Upon request, I will provide a copy of this form.

Client Signature _____ Date: _____

Witness Signature _____ Date: _____

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New Beginnings Mental Health Coaching and Counseling

Date:_____

Name: _____

Our sessions are conducted in any of the formats such as over the phone, in the office, or virtual (Zoom, Facetime, etc.).

The cell number for Antonio is (530) 409-2288 and for Maria (530) 848-5670
Missing or rescheduling sessions is strongly discouraged. If an unforeseen event does require you to reschedule, I must be notified 24 hours prior to the scheduled session. Please remember that not completing, or partially completing your assignments is not a reason to reschedule. If assignments are not complete, it is very important that we work together during your scheduled session to strategize, overcome obstacles, and establish next steps.
If notification is not given 24 hours prior to the scheduled session time, the session will be considered missed and thereby forfeited.

Mental Health Coach Disclaimer of Liability: Client hereby employs as Mental Health Coach, for the purpose of supporting the Client with respect to Client's self-awareness, vision and goals, and strategic plans, has experience in such matters and agrees to render such coaching services.

I have read and agreed to the Policies and Disclaimer of Liability.

Client's Signature (Date) _____

Mental Health Coach Signature (Date)

_____

Once you have completed the form, please email it to Info.kentuckyavechurchofchrist@gmail.com or bring it to the initial session. Any questions, be sure to contact me.