CLIENT INFORMATION—ADULT

(Revised December 2023)

Today's Date: _____

Client Name: _____ Form Completed By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone (cell) (work): _____

E-Mail: _____ (Confidentiality of email communication cannot be guaranteed.)

Date of Birth: _____ Gender: Male _____ Female _____

Employment: Full-time _____ Part-time _____ Not employed _____ Student _____

Occupation_____ Employer/School_____How Long? _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

General Information

Have you ever sought help in counseling or psychotherapy before? Y N

Provider's name: _____

Date of service: _____

Are you currently working with another counselor? Y N

Provider's name: _____

Have you ever been treated by a psychiatrist? Y N

Provider's name: _____

Date of service: _____

Have you ever been hospitalized for a mental health reason? Y N

Date of hospitalization: _____

How did you find out about Travis Dale Counseling? (please circle all that apply)

Friend/Word of Mouth Pastor/church Google Search/Counseling LifeChangers Christian Counseling
New Life Counseling(Arizona Baptist Children's Services) Christian Counselor Directory (online)
Psychology Today (online) Facebook Instagram LinkedIn Twitter

Family of Origin Information

By whom were you raised? (please circle)

Both parents mother father grandparent other

Were your parents married to each other? Y N

Did they remain married? Y N

Your age at their divorce, separation or death:_____

How many siblings do you have? _____

Where are you in the birth order? _____

Which best describes the atmosphere of the home in which you grew up (please circle all that apply):

Nurturing Calm Neutral Conflicted Angry Abusive Loving Emotionally volatile

Relational Information

Current relational status:

Single, never married: ____ in relationship _____ not in relationship

Married: Name of spouse or significant other:_____

Anniversary date:_____

Separated: Date of initial separation:_____

Divorced: Date of final divorce decree:_____

Cohabiting: When began:_____

Indicate number of marriages/cohabitations (including current one): _____

Which best describes your current relationship (please circle all that apply):

Abusive bland calm conflicted loving satisfying unfulfilling

Please list those with whom you currently live:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Information

Doctor: _____ Telephone Number:_____

Are you currently under a doctor's care? Y N

If yes, please explain: _____

_____

May we contact your physician? Y N

List medications:_____

Please list any significant medical conditions (HBP, Gastric Reflux, Fibromyalgia, etc.):

_____

Are you having trouble sleeping? Y N

Do you have trouble getting to sleep? Y N

Do you have trouble staying asleep? Y N

Do you have recurrent dreams or nightmares? Y N

Do you have trouble concentrating or getting organized? Y N

Have you noticed a recent change in your weight in the last 3-6 months? Y N

Gain or loss? How many pounds?_____

Have you noticed a recent change in appetite? Y N

Increase or Decrease?

Have you noticed a recent change in your sexual desire? Y N

Increase or Decrease?

Do you have any unexplained crying spells? Y N

Do you often feel any tightness in your chest or throat or heart palpitations? Y N

Do you often feel "nervous" or "anxious"? Y N

Do you often complain of headaches or stomach aches? Y N

Substance Use Information

What is your current substance usage, including alcohol and caffeine:_____

_____

Do you recognize any addictions in your life (alcohol, drugs, gambling, sex, internet, work)? Y N

Please describe: _____

Emotional Information

Do you ever feel like running away? Y N

Do you ever feel like hurting yourself? Y N

Have you ever attempted suicide? Y N

Have you recently suffered a significant loss (job loss, death, divorce, etc) Y N

Who? _____ When? _____

Do you believe you have ever been a victim of abuse (emotional, physical, sexual, verbal)? Y N

Where? _____ When? _____

Please describe: _____

Are you happy with your job or classes? Y N

Do you have a "best friend?" Y N

Who? _____

What do you do for fun? _____

Presenting Concerns

Please describe the reason(s) for which you are seeking counseling at this time:

_____ _____

Client Signature Date

INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with ethical standards, the counselor is required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside when he/she feels it will facilitate the work with you/your family. Your name and any uniquely identifying information about you/your family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let your counselor know if you are withholding consent.**

Professional Records

The laws and standards of counseling require the keeping of case records. Records are locked and kept on site. You are entitled to receive a copy of your records or a summary of your care if you make a written request These request forms for the summary of your care are available to you. Please note that these are professionally-held records and can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records it is recommended that you review them with your counselor so that the contents can be discussed. You have the right to amend your record, if you find something disagreeable or concerning. Your record will NOT be disclosed to others unless you ask the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information. Meetings will be scheduled at mutually convenient times.

AUTHORIZATION TO TREAT

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

_____

Client Name

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

Fees & Agreement

In order to be fully informed about the counseling you will be receiving, please read through this following agreement, sign and date it at the bottom. This form must be signed and the client information form must be completed before the first session.

QUALIFICATIONS and AFFILIATION

Travis Dale MA MFT, BCPC is a Board Certified Pastoral Counselor, with over 30 years of experience, who received a Master of Arts in Counseling/Marriage and Family Therapy from Ottawa University and a Bachelor of Science in Christian Ministries from Arizona Christian University. He also holds a ministerial license through the state of AZ. **Travis Dale** is not a behavioral health professional and cannot prescribe medicine or diagnose mental illness. Clients will be referred to outside sources when treatment required is beyond the scope of care available here.

COUNSELING FEES

Payment is due at the beginning of each session and accounts must be kept current in order to continue counseling. Cash, checks (*payable to Travis Dale Counseling*), credit card, Venmo, Zelle or HAS/FSA are accepted forms of payment. Please note that we do not accept insurance, and you are responsible to pay for services rendered.

Fee Schedule:

- General Sessions (50 minutes): $180 or agreed amount on sliding scale _____ (per session)

CLIENT EXPECTATIONS

Please plan to arrive 5 minutes prior to your appointment so the session can begin on time. You may be asked to complete homework assignments, or read books in conjunction with your counseling. Your commitment to the counseling process will greatly determine the outcome of your experience.

CONFIDENTIALITY

Your counselor will adhere to commonly accepted codes of privacy and confidentiality in counseling ethics. All counseling notes and client files are locked and only accessible to the counselor. There are situations, however, in which the law requires that certain information can be revealed without your consent. Under the discretion of the pastoral counselor, if there is any indication that you may be a danger to yourself or others, or are involved in the abusing of a minor, your information may be disclosed to appropriate mental health services or law enforcement. Also, an issue may occasionally arise that would benefit from the counsel or involvement of a mental health professional.

RIGHTS AS A CLIENT

You are entitled to information about any procedures, methods of counseling, techniques and possible duration of recommended care. You have the right to end counseling at any time without any moral, legal or financial obligations other than those already accrued. You have the right to expect confidentiality within the limits described.

CANCELLATION POLICY

I request that you notify me at least 24 hours before your scheduled appointment time if you need to cancel or reschedule a session. There is fee of $100 or 1 prepaid Bundle session credit if you fail to give notice before 24 hours.

By signing below, you are acknowledging that you understand and accept the guidelines stated above.

Signed _____Date _____

Counselor _____Date _____