

Please fill out completely and return to LifePoint, or email back to counseling@lifepointnv.com



Biblical Counseling

INITIAL INTAKE ASSESSMENT

Name: _____ Age: _____ Date: _____

Telephone: Day: _____ Evening: _____ Cell: _____

Address: _____ City: _____ Zip: _____

Marital Status: _____ How Long: _____ Spouse's Name: _____

Email Address: _____

Children:

<u>Name</u>	<u>Age</u>	<u>Name</u>	<u>Age</u>
_____	_____	_____	_____
_____	_____	_____	_____

Emergency contact: _____ Phone Number: _____

How long: LifePoint member _____ How long: LifePoint regular attender _____

LifePoint ministries I am involved in: _____

1. Who referred you to this program? _____

2. What are you seeking help for? _____

3. When did this start? _____

4. Have you ever had counseling before? _____ If so, what for and where? _____

5. Are you taking any medications now? _____ Please list dosage, purpose and physician.

6. Family physician: _____ Phone number: _____

7. What do you expect or hope to be different in your life as a result of this counseling?

Biblical Counseling

CHILDHOOD HISTORY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent Moves | <input type="checkbox"/> Alcohol/Drugs | <input type="checkbox"/> Death of Family Member |
| <input type="checkbox"/> Parents Divorce | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Abuse/Neglect |
| <input type="checkbox"/> Parents Remarriage | <input type="checkbox"/> Parent Conflict | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Parents Separated | <input type="checkbox"/> Parent Job Loss | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Family Illness | <input type="checkbox"/> Financial Stress | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Loss of Job | <input type="checkbox"/> Personal Illness | <input type="checkbox"/> Learning Problems |
| <input type="checkbox"/> Other _____ | | |
-

INFORMATION ABOUT YOUR DEVELOPMENT UP TO AGE 18 MAY HELP CLARIFY A PROBLEM YOU MIGHT PRESENTLY BE HAVING. PLEASE PLACE A CHECKMARK IN THE BLANK FOR THOSE THAT APPLY TO YOU.

- | | | |
|--|--|---|
| <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Avoiding Others | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Nervous | <input type="checkbox"/> Fidgety/Restless |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Abuse/Neglect | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Talking | <input type="checkbox"/> Refusing to Talk | <input type="checkbox"/> Bad Dreams |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Frequent Ear Problems | <input type="checkbox"/> School Behavior |
| <input type="checkbox"/> Feeling Rejected | <input type="checkbox"/> Visual Difficulties | <input type="checkbox"/> Fearful Leaving Home |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Strong Willed | <input type="checkbox"/> "Worry Wart" |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Toilet Training | <input type="checkbox"/> Few Friends |
| <input type="checkbox"/> Ran Away From Home | <input type="checkbox"/> Small for Age | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Repeated Grade | <input type="checkbox"/> Fighting | <input type="checkbox"/> Picked On |
| <input type="checkbox"/> Reading Problem | <input type="checkbox"/> Trouble with Police | <input type="checkbox"/> |

How did your parents/caretakers discipline you while you were growing up? _____

What reasons were you disciplined? _____

FAMILY HISTORY:

HOW WOULD YOU RATE YOUR PRESENT RELATIONSHIPS WITH THE FOLLOWING:

(If an item doesn't apply, check "N/A")

FATHER	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
MOTHER	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
BROTHER	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
SISTER	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
SPOUSE	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
SON	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
DAUGHTER	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
IN-LAWS	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A
EMPLOYER	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>	Problem For You	<input type="checkbox"/>	N/A

EDUCATIONAL HISTORY:

High School Attended: _____ Location: _____

Highest Grade Completed: _____ Education Beyond High School? Yes No

College: _____ # of Years _____ Field of Study: _____ Maj: _____ Minor: _____

College: _____ # of Years _____ Field of Study: _____ Maj: _____ Minor: _____

Vocational or Technical Training: Yes No

Full Time: _____ Part Time: _____ GPA: _____ Are you presently a student? Yes No

OCCUPATIONAL HISTORY:

Are you presently employed? Yes No Type of Work: _____

How long have you held your present job? _____

Have you had problems gaining employment? Yes No

What other jobs have you had? Why did you leave? _____

Describe your relationship with present and past employers: _____

If you are a homemaker, are there any things that you usually do that you didn't get done this past week or two?

Have you served in the Military? Yes No If yes, what branch of Service? _____

When and how were you discharged? _____

MARITAL HISTORY:

Marital Status: Married Separated Divorced Remarried Widowed Single
(Skip section)

	<u>First</u>	<u>Second</u>	<u>Third</u>
Marriage	Date _____	Date _____	Date _____
Separation	Date _____	Date _____	Date _____
Divorce	Date _____	Date _____	Date _____
Widowed	Date _____	Date _____	Date _____

Are you considering separation or divorce? Yes No

Are you a divorced custodial parent? Yes No

Are you married raising minor children? (If No, skip next section.) Yes No

Do you and your spouse:

Agree on the methods of discipline of the children? Yes No

Share common values in the rearing of your child? Yes No

Feel the parent/child interaction is positive? Yes No

Spend quality time as a family? Yes No

If divorced, why did you divorce? _____

Describe the major conflicts you have with your spouse and how you both have responded:

Conflict: _____

Your Response: _____ Spouse's Response: _____

PRIOR COUNSELING HISTORY:

Have you had prior Mental Health Treatment? Yes No If yes, date: _____

Was this person a: Psychiatrist Psychologist Clinical Social Worker
 Clinical Counselor Minister Other: _____

Were you given a diagnosis? Yes No (If yes, what was it?) _____

What were the major issues you dealt with in counseling? _____

Was this a successful experience for you? Yes No If not, please explain _____

Have you ever been hospitalized for emotional problems? Yes No

If yes: Name of Hospital _____ Date: _____

Location _____ How Long? _____

Doctor who treated you _____

Medications you took _____

Do you still take medication? Yes No

ALCOHOL/DRUG HISTORY:

Do you have a history of Alcohol/Drug Abuse? ___ Yes ___ No

Please list name of drug (e.g., marijuana, cocaine, etc.): _____

Drug: _____ Length of use: _____ Last used: _____ Amount Used: _____

Drug: _____ Length of use: _____ Last used: _____ Amount Used: _____

If you are using alcohol or drugs, has this resulted in:

- ___ Marital Problems ___ Memory Blackouts ___ Problem with Family or Friends
- ___ Preoccupation w/ Alcohol/Drugs ___ Problems on the Job ___ Loss of Control
- ___ Legal Problems ___ Withdrawal Symptoms ___ Physical Problems
- ___ Periods of Abstinence ___ Financial Problems ___ Charges of DUI or DWI

LEGAL HISTORY:

Have you been in trouble with the Law? ___ Yes ___ No If yes, please check those that apply to you:

___ Trouble with the law as a juvenile ___ Have you ever been arrested? For what?

___ Have legal matter pending? ___ Have you ever been convicted of a crime?

Explain any areas checked: _____

SOCIAL HISTORY:

Do you have any close friends you can confide in about personal matters? ___ Yes ___ No

How many? _____ How often do you speak with them? _____

What kind of leisure or recreational activities do you enjoy? _____

Are these done by yourself or with others? _____

Describe how you have been getting along with others and how you have been or not been helped by others:

MEDICAL HISTORY:

Please place an "X" in the left-hand column if this condition exists. In the right column, write, "self, father, mother, sister, brother, aunt, uncle, etc."

___ Alcoholism	_____	___ Suicide	_____
___ Allergies	_____	___ Cancer	_____
___ Mental Retardation	_____	___ Diabetes	_____
___ Obesity	_____	___ Epilepsy	_____
___ A degenerative disease	_____	___ High Blood Pressure	_____
___ Mental Health Problems	_____	___ Heart Trouble	_____
___ Other	_____		

SPIRITUAL HISTORY:

If you have attended a church/religious group, answer the following:

Name(s) of church/group: _____

Length of Affiliation and when: _____

Describe your experience with church/religious group: _____

Describe your present relationship with God: _____

CURRENT SOURCES OF STRESS:

Please list your most significant sources of stress or worry:

1. _____

2. _____

What is the main goal you wish to attain in seeking Biblical Counseling? _____

What have you done to manage these problems? _____

Envision how your life would be different if you could receive support in the midst of these problems: _____

Additional Information: Please add any information you feel which might be helpful in assisting your treatment:

Your signature below indicates you understand the questions, could ask for assistance, if needed, and that this information is true to the best of your knowledge.

Signature Date Received By Date

Biblical Counseling



INFORMED CONSENT TO SERVICES

A Biblical Counselor is a person trained to come alongside others and provide encouragement, comfort, and care. Biblical Counselors are paraprofessionals (in other words, we are not licensed, paid professional therapists). As Biblical Counselors, we are trained in the skills of listening, clarifying and goal setting, while accurately applying the Word of God to people's lives. Our training and counseling are supervised by the Care Pastor. We offer a response to your personal or family needs based on the Christian understanding of comforting others as God has comforted us. As such, there are no fees incurred in seeing a Biblical Counselor.

Biblical Counseling Agreement Form

As a counselee, I understand the following:

1. The contract I have with the Biblical Counselor(s) is paraprofessional.
2. In some cases, I may be seen by co-counselors.
3. All counseling is confidential. This confidentiality includes the Biblical Counselor's supervisor(s) and/or Pastoral Staff, as necessary. (See "Duty To Warn" for exceptions.)
4. I will meet with my counselor for six (6) sessions, usually one 50-minute session per week in the Church counseling offices.
5. At the end of the six (6) sessions, a reassessment of the counseling situation will be made by Both the Biblical Counselor and myself. At that time, a new decision will be made concerning the best course of action for me. This may include referral to a professional therapist, a continuation of my counseling with the Biblical Counselor, or termination of the counseling sessions.
6. Out of courtesy to my counselor, I will give at least 24 hours prior notice before canceling an appointment.

I have reviewed the above conditions with my counselor(s) and agree to abide by them.

Counselee's Printed Name

Date

Counselee's Signature (If under 18, Parent or Guardian)

Date

Counselor(s)

Date

I would be willing to allow my counseling sessions to be taped for professional supervisory purposes only.

Counselee's Signature

Date

Supervision

To meet our objective of providing the highest level of care possible, all Biblical Counselors are under supervision.

Confidentiality

Your confidentiality is guarded at all times. Nevada law does require that counselors have a duty to warn the appropriate individuals if the counselee intends to take harmful, dangerous, or criminal action against themselves or others. Counselors are also mandated to report any incidence of “reasonably suspected child abuse” (physical or sexual) and elderly abuse to the appropriate authorities. Couselees in a suicidal condition will be referred to law enforcement or mental health professionals who are capable of providing the appropriate treatment and protection.

WAIVER OF LIABILITY

THE UNDERSIGNED, having sought Biblical Counseling, as such, as adhered to by **LIFEPOINT**, a nonprofit religious organization, hereby acknowledges their understanding of the following conditions and further releases from liability **LIFEPOINT**, its Biblical Counselors, affiliates and insurers, and agree to defend, indemnify, and hold them harmless from any and all claims for damages or injuries, whether physical, emotional or otherwise, which may arise from or relate in any way, whatsoever, to the aforesaid counseling services, the same being identified as follows:

1. It is understood by the participant counselee, that all Biblical Counseling will be provided by Biblical Counselors, not licensed therapists, but said Biblical Counselors shall be under the supervision of the Care Pastor.
2. That all counseling provided in the Biblical Counseling program is provided in accordance with the Biblical principles as adhered to by **LIFEPOINT** and are not necessarily provided in adherence with any local or national psychological or psychiatric association.
3. That no representation has been made, either expressly or implied, that Biblical Counseling, as conducted by the above-mentioned Biblical Counselors is accepted as customary psychological and psychiatric therapy within the definitional terms utilized by those professions.

Counselee’s Printed Name

Date

Counselee’s Signature (If under 18, Parent or Guardian)

Date

Biblical Counselor

Date

Supervisor

Date

Biblical Counseling



DUTY TO WARN

LIFEPOINT Biblical Counselors abide by Nevada law which requires incidences of “reasonably suspected child abuse” to be reported to law enforcement or child protective agencies (NR5432B).

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION REMAIN RIGHTS OF ALL COUNSELEES. HOWEVER, SOME COURTS HAVE HELD THAT, IF AN INDIVIDUAL INTENDS TO TAKE HARMFUL, DANGEROUS, OR CRIMINAL ACTION AGAINST ANOTHER HUMAN BEING, OR ONESELF, IT IS THE COUNSELOR’S DUTY TO WARN APPROPRIATE INDIVIDUALS OF SUCH INTENTIONS. COUNSELORS ARE MANDATED TO REPORT ANY INCIDENCES OF “REASONABLY SUSPECTED CHILD ABUSE” (PHYSICAL OR SEXUAL), ELDER ABUSE, OR SUICIDE ATTEMPTS.

I HAVE READ THE ABOVE AND UNDERSTAND THE COUNSELOR’S SOCIAL AND ETHICAL RESPONSIBILITY TO WARN WHEN HARMFUL, DANGEROUS, OR CRIMINAL ACTION IS STRONGLY INDICATED. I FURTHER UNDERSTAND THE COUNSELOR’S LEGAL RESPONSIBILITY TO NOTIFY THE PROPER AUTHORITIES IN CASES OF “REASONABLY SUSPECTED CHILD ABUSE,” ELDER ABUSE, OR A SUICIDE ATTEMPT.

Counselee’s Printed Name

Date

Counselee’s Signature (If under 18, Parent or Guardian)

Date

Counselor

Date