



Confidential Client Intake Forms (Parent/Child)

Dear Friend,

I am grateful that you have welcomed me into your life at this time. It is never easy to ask for help. I admire the courage, faith, and humility this first step represents on your part. It is my prayer that God will bless this initial step and the steps that will follow in counseling.

My goal is to provide the highest quality, Christ-centered counseling to individuals and families who are hurting and confused. This means that the counseling you receive will focus upon helping you identify how the beliefs, values, and allegiances of your heart (Prov. 4:23; Matt 6:21; Luke 6:45) express themselves in your emotions, relationships, decision making, and identity. As your counselor, I will help you examine how your heart has been influenced and what your heart is currently seeking. Through intelligent and guided repentance, faith, and obedience we will seek to effectively love God and love neighbor (Matt. 22:37-40) in order to experience the love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control (Gal. 5:22-23) God intends for us.

The next step in counseling for you is to complete the intake forms you are now reading. They are designed to allow the counseling process to start smoothly. **You will need to allow approximately 45 minutes to complete these forms.**

The counseling forms are designed to **(1)** help me to get to know you in a comprehensive, holistic, and efficient manner and **(2)** help you organize your thoughts about your counseling objectives.

- **The first appointment is for one or both parents/guardians only. The minor should not attend this appointment with you.** When counseling minors, establishing a relational atmosphere is essential for effective counseling. Bringing your child to this data gathering appointment inhibits your counselor's ability to initiate counseling in an effective manner.
- **The parents should complete the next seven (7) pages of this packet** – up to and including the “Consent to Counsel”. As you complete these materials provide your perspective of what your child is experiencing at this time. **The final two (2) pages should be completed by the minor** and brought to the first appointment by the parent/guardian.

NOTE CONCERNING MEDICATION: If you are taking any prescription medication(s) please do not alter your dose on the day of your appointment. If have recently begun a new medication, please allow approximately two weeks before scheduling your appointment.

Office hours may vary, please contact the office for availability. Counseling sessions will require you to be in my office for approximately one hour. Please be prepared for this. Bathroom facilities are available. Childcare is not provided.

I am grateful to be able to serve you at this time and to be a part of the journey God has for you. I look forward with a sober anticipation towards playing a role in your progress and hope.

In Christ,

Celeste Vernon

Celeste D. Vernon, M.A.

Counselor

The Center for New Beginnings

Directions to the Augusta Office

I am seeing clients in Augusta at Fleming Baptist Church, 3027 Peach Orchard Rd. Fleming Baptist Church is located approximately 3 blocks north of the Bobby Jones Expressway (I-520) and is across the street from Ryan's restaurant. The room we will meet in is in the sanctuary building. As you sit in the parking lot you will see the sanctuary and an education building directly behind it. The buildings are connected by a breezeway. Walk through the breezeway and enter the sanctuary building. Take the hall to the left and I will be in the 2nd room to your left. If I have someone with me please wait in the choir room that you will see at the end of the hall in front of you.

Directions to the Waynesboro Office

My office in Waynesboro is at the Center for New Beginnings, 727 W. 6th Street. The Center for New Beginnings is located approximately 1 mile west of the Burke County Courthouse and sits just off the road between the Pineland Bakery and the Burke County Department of Family and Children Services. (Unfortunately there is no street number posted on the building.) When you arrive please have a seat in the waiting room and I will be with you shortly.

Confidential Client Intake Forms (Parent/Child)

Date: _____

Parent Information:

Parents' Names: _____ Age Male: _____ Age Female: _____

Address: _____ City/State: _____ Zip : _____

Primary Phone Numbers: _____ May we leave a message here: Yes No

Second Phone Numbers: _____ May we leave a message here: Yes No

Occupation / Employer: _____

Birth date: _____ / _____ / _____ Email Address: _____

Date of Marriage: _____ Your ages when married: Husband _____ Wife _____

List highest degree(s) earned: _____

School or Institution: _____

Give *brief* information about any previous marriages:

Ex-Spouse's Name	Year Married	Length of Marriage	Reason for Divorce	# Kids

** Other relevant information can be written on the back of this page.*

Sibling's Names	Living	Age	Gender	At Home	Married	Special Condition(s)	*PM/A/MC
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		
	Y / N		M / F	Y / N	Y / N		

** Check this column if child is by previous marriage (PM), adoption (A), or lost to miscarriage (MC).*

Minor Who Will Be in Counseling:

Name: _____ Age: _____

Birth date: _____ / _____ / _____ Social Security Number: _____

Nickname: _____ Email Address: _____

Grade: _____ School: _____

Is your child coming to counseling voluntarily? Yes No Uncertain

Has your child ever lived outside your home? Yes No When? _____

If yes, where and how long? _____

Spiritual / Religious Information

DO YOU CONSIDER YOUR CHILD A RELIGIOUS PERSON? Yes No

Church Name: _____ Number of Years at Church: _____

Pastor's Name: _____

Denominational Preference: _____ Church Attendance: _____ Times per month

Is your child a part of a Sunday School class? Yes No Is your child a part of a home Bible Study? Yes No

Please list any ministry involvement: _____

HAS YOUR CHILD BEEN BAPTIZED? Yes No When? _____

Please answer the following questions with your parental assessment of your child's spiritual life.

DO YOU PRAY TO GOD? Yes No How often? _____

What do you pray about? _____

HAVE YOU COME TO THE PLACE IN YOUR SPIRITUAL LIFE WHERE YOU KNOW WITH CERTAINTY THAT IF YOU WERE TO DIE TONIGHT YOU WOULD GO TO HEAVEN?

Yes No Uncertain

If yes, what is your basis for answering the above question as you did? _____

HAVE YOU RECEIVED JESUS CHRIST PERSONALLY AS YOUR SAVIOR?

Yes No Uncertain Don't know what you mean

If yes, how do you know that Jesus Christ is your Savior? _____

Do you read the Bible? Yes No How often? _____

Do you have personal devotions? Yes No How often? _____

Describe your personal devotions: _____

Do you have family devotions? Yes No How often? _____

Describe your family devotions: _____

Please note any recent changes in your spiritual life: _____

Health Information

Has your child had counseling, psychotherapy, or seen a psychiatrist before? Yes No

Age	Duration	Counselor/ Center	Issue(s) / Topics(s) / Diagnosis	* Your Evaluation of Counseling

** Use back of this page if necessary or if you need more space*

Approximately how many hours of sleep does your child get each night? _____

When do they normally: go to bed? _____ fall asleep? _____ wake up? _____ get out of bed? _____

What do they normally do between going to bed and falling asleep? _____

Describe any recent changes in sleep habits: _____

State of current health: Very good Good Average Declining Other: _____

Date of last medical examination: _____ Results: _____

Current illness, injury, or disability: _____

Is your child presently taking any medication? Yes No Prescribing Doctor(s): _____

Medication	Dosage	Frequency	Prescribed for...	Date began taking...

** Use back of this page if necessary*

Has your child used drugs for other than medical purposes? Yes No When? _____

What? _____ Amounts/Dosages: _____

Do they drink alcoholic beverages? Yes No When? _____ How much? _____

Describe their eating habits or changes in appetite: _____

Describe their exercise routine: _____

Current weight? _____ lbs Weight changes: **6 months** +/- _____ lbs **1 Year** +/- _____ lbs **5 Years** +/- _____ lbs

Number of non-working hours per week spent watching television _____ on computer _____ hobbies _____

Check any of the following words which best describe your child **at this time**:

- | | | | | |
|---|------------------------------------|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Impatient | <input type="checkbox"/> Calm | <input type="checkbox"/> Extrovert | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Serious | <input type="checkbox"/> Likable | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Self-Confident | <input type="checkbox"/> Moody | <input type="checkbox"/> Easy-going | <input type="checkbox"/> Leader | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Persistent | <input type="checkbox"/> Blue | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Submissive | <input type="checkbox"/> Introvert |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Excitable | <input type="checkbox"/> Good-natured | <input type="checkbox"/> Imaginative | <input type="checkbox"/> Quiet |

Please complete the following in one or two sentences:

1. Please describe the current problem, as you understand it. _____

2. What have you done about it (*most* effective and *least* effective)? _____

3. Other than counseling, what help are you seeking? _____

4. Who referred you to this ministry for help? _____

5. Please describe any family history (the family that you grew up in), which might be pertinent to the concerns that you bring to counseling (your relationship with your parents, their relationship with each other, significant losses and/or events): _____

6. Please list and describe key *positive* peer or role model relationships in your child's life _____

7. Please list and describe key *negative* peer or role model relationships in your child's life _____

8. What do you believe you will have to change to see the progress you desire? _____

9. Is there any other information we should know? _____

Counseling Policy Review

Instructions for Policy Review: After carefully reading each policy please *place your initials* in the space provided to indicate your understanding and agreement with each policy. If you have questions please direct them to your counselor before your initial meeting. If for any reason you are unable to sign these forms, counseling services will be denied to you.

FINANCIAL POLICY

Celeste Vernon is solely supported and able to operate because of your financial donations. Her expenses are not underwritten by an individual, church, or corporation. Therefore, it is the responsibility of each counselee to maintain the operating expenses she incurs. The fair-market-value of counseling in the CSRA ranges from \$75.00 to \$125.00 per 50-minute session. Your responsibility is to pray about the amount God would have you donate for the counseling you receive and be obedient to Him in your giving.

***** Initial here if you understand and agree with this Financial Policy:** _____

APPOINTMENT CANCELLATION POLICY

I require a 24 hour notice if you wish to cancel or are unable to keep an appointment. E-mail is *not* an acceptable form of contact. If you fail to give a 24 hour notice you will be expected to pay a missed appointment fee.

\$25.00 for the first appointment missed or cancelled with insufficient notice.

\$50.00 for the second appointment missed or cancelled with insufficient notice.

\$75.00 for all subsequent appointments missed or cancelled with insufficient notice.

All clients are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to: (1) process payments at your request, (2) to bill for late cancellations or missed appointments, or (3) to reimburse Crossroads for returned checks. In each case you will be called and a message will be left (if answering service is available) before payments are processed. A \$10.00 service charge is added to your donation for returned checks.

Credit Card Number: _____ - _____ - _____ - _____ Exp Date: _____ / _____

Type of Card: MasterCard Visa

***** Initial here if you understand and agree with this Cancellation Policy:** _____

PHILOSOPHY OF CARE

I am committed to providing a balance in my approach to counseling. By biblical counseling I mean that your counselor is a Christian with special training and experience in applying the truths of the Bible to life. I believe that the Bible speaks to all of life and to all of its problems, but sometimes it takes careful thought and prayerful wisdom to know how to make those connections. I don't believe that the Bible is simply a how-to book or a recipe book for happiness.

I believe that the Bible ultimately points us to a person and a relationship - Jesus Christ as our Savior and Redeemer. I believe that real change comes when people learn to see themselves and their problems in the context of a living, vital relationship with Christ. This does not mean that you must be a Christian to profit from counseling, although I believe that deep and lasting change is brought about only by God himself. However, the Bible is never brought to bear in an artificial or heavy-handed way.

When necessary I will work with your physician to ensure you receive the appropriate medical care in conjunction with the counseling services you receive.

***** Initial here if you understand and agree with this Philosophy of Care:** _____

CONFIDENTIALITY CLAUSE

The privacy and confidentiality of our conversations and records are a privilege of yours and are protected by ethical principles in all but a few circumstances. Those exceptions are limited to the following: known or suspected child or elderly abuse; the intent to take criminal actions against another person; active suicidal ideations; and, counseling that is mandated by a legal authority, then it is assumed by your signature that you agree that your counselor may give/receive updates and opinions and share records for the purpose of professional continuity.

Confidentiality for my counseling is defined by pastor-parishioner privilege because I am affiliated with a para-church organization and, therefore, operate as an agent of the church (ministers) not of the state (licensed). This means counseling records cannot be subpoenaed and counselors cannot be asked to testify in court cases. If your counseling subject requires professional representation in a court setting by a counselor, I will likely not be the best-fit as a counselor for you.

I reserve the right to consult with other counselors for the purpose of providing the highest level of care. Being affiliated with a para-church ministry, I reserve the right to involve the church where you hold membership for the purpose of cooperative pastoral care.

***** Initial here if you understand and agree with this Confidentiality Clause: _____**

WAIVER OF LIABILITY

In seeking counseling from *Celeste Vernon, Independent Contractor Affiliated with The Center for New Beginnings*, you must acknowledge your understanding of the following conditions and further release *The Center for New Beginnings*, its agents, affiliates, counselors, employees, Board of Directors, and all ministry team leadership, from any legal liability, claim, or litigation arising from your participation in this voluntary program:

1. Counseling will be provided by a counselor from a pastoral perspective (Celeste Vernon, M.A.). Your counselor is *not* a state licensed counselor through the Georgia Composite Board;
2. All counseling is provided in accordance with the biblical principles adhered by *The Center for New Beginnings* and are not necessarily provided in adherence to any local or national psychological or psychiatric association;
3. No representation has been made, either expressly or implied, that the biblical counseling, as conducted by the above mentioned counselor, is accepted as customary psychological and/or psychiatric therapy within the definitional terms utilized by those professions;
4. It is understood by the participant counselee(s) that all complaints and grievances will be heard by the Executive Director. If the goal of reconciliation cannot be achieved between the aforementioned parties, then the participant counselee(s) may elect to involve *Peacemaker Ministries, Inc.*, at their expense, for the purpose of mediation or arbitration.

***** Initial here if you understand and agree with this Waiver of Liability: _____**

CONSENT TO COUNSEL

Having read and understood the

Financial Policy

Appointment Cancellation Policy

Confidentiality Clause

Waiver of Liability

Philosophy of Care

I, _____ (print name)

grant permission for *Celeste D. Vernon, M.A.* to render counseling services to me and the names listed below
(please include the names of those who may be involved in the counseling process):

_____	_____
_____	_____
_____	_____

I also understand that *Celeste D. Vernon* may terminate services for noncompliance with the plan of care and/or agreed upon administrative issues, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior, or for other issues agreed upon by the Board of Directors.

* * * * *

Please sign to indicate the following:

1. You have read the policies in this document;
2. You agree with and understand each of these policies; and,
3. You are enrolling yourself into counseling of your own will.

Client Signature

Date

Client Signature (*if more than one client*)

Date

Counselor Signature

Date

Confidential Client Intake Forms (Minor)

Date: _____

Name: _____ Gender: Male / Female Age: _____

Address: _____ City/State: _____ Zip: _____

Grade in School: _____ School: _____

Birth date: ____ / ____ / ____ Email Address: _____

What are your thoughts about coming to counseling? _____

SPIRITUAL / RELIGIOUS INFORMATION

Church Name: _____ Church Attendance: _____ Times per month

DO YOU PRAY TO GOD? Yes No How often? _____

What do you pray about? _____

HAVE YOU COME TO THE PLACE IN YOUR SPIRITUAL LIFE WHERE YOU KNOW WITH CERTAINTY THAT IF YOU WERE TO DIE TONIGHT YOU WOULD GO TO HEAVEN?

Yes No Uncertain

If yes, what is your basis for answering the above question as you did? _____

Do you read the Bible? Yes No How often? _____

Please note any recent changes in your spiritual life: _____

OTHER INFORMATION

Please provide the following information about your home:

If you were reared by someone other than your own parents, briefly explain: _____

Number of older brothers: _____ Older Sisters: _____ Younger brothers: _____ Younger Sisters: _____

Step/half: _____ Step/half: _____ Step/half: _____ Step/half: _____

The town I grew up in was ____ urban ____ suburban ____ small town ____ rural ____ changed frequently.

My family's financial situation was ____ poor ____ lower middle ____ middle class ____ upper middle class ____ wealthy.

Did you have any significant traumatic events as a child? ____ Yes (*please describe on back*) ____ No

Which of the following words best describe your home of origin (check all that apply):

<input type="checkbox"/> Traditional	<input type="checkbox"/> Authoritarian	<input type="checkbox"/> Calm	<input type="checkbox"/> Divorced	<input type="checkbox"/> Lonely
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Perfectionist	<input type="checkbox"/> Critical
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Affectionate	<input type="checkbox"/> Affirming	<input type="checkbox"/> Safe	<input type="checkbox"/> Permissive
<input type="checkbox"/> Unpredictable	<input type="checkbox"/> Always Changing	<input type="checkbox"/> Boring	<input type="checkbox"/> Other: _____	

Check any of the following words which best describe you *at this time*:

- | | | | | |
|---|------------------------------------|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Impatient | <input type="checkbox"/> Calm | <input type="checkbox"/> Extrovert | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Serious | <input type="checkbox"/> Likable | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Self-Confident | <input type="checkbox"/> Moody | <input type="checkbox"/> Easy-going | <input type="checkbox"/> Leader | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Persistent | <input type="checkbox"/> Blue | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Submissive | <input type="checkbox"/> Introvert |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Excitable | <input type="checkbox"/> Good-natured | <input type="checkbox"/> Imaginative | <input type="checkbox"/> Quiet |

Check any of the following struggles or difficulties that you are experiencing *at this time*:

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Parents on my back | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> In-Laws |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Guilt | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Marital Intimacy | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Envy |
| <input type="checkbox"/> Bitterness | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Lifestyle Change | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Addiction | <input type="checkbox"/> Deceit |
| <input type="checkbox"/> Pornography | <input type="checkbox"/> Financial Management | <input type="checkbox"/> Suicidal Thinking | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Peer Pressure | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Work |
| <input type="checkbox"/> Conflict Resolution | <input type="checkbox"/> Relationships | <input type="checkbox"/> Bad Memories | <input type="checkbox"/> Purpose |
| <input type="checkbox"/> Security | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Self-Injury | <input type="checkbox"/> Identity |
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Time Management | <input type="checkbox"/> Codependency | <input type="checkbox"/> Family |
| <input type="checkbox"/> Responding to Abuse (Type: _____) | | <input type="checkbox"/> Psychological Diagnosis (_____) | |

Please complete the following:

- In order to understand me _____
- My ambition in life is to _____
- What really hurts me _____
- I get nervous when _____
- I wish I could lose my fear of _____
- What I wish I could change about myself _____
- My *best* childhood memory _____
- My *worst* childhood memory _____
- My father is/was _____
- My mother is/was _____
- My biggest regret is _____
- What I like/understand least about the opposite sex is _____
- My greatest achievement is _____
- My role in my current family is _____
- For refuge/rest I turn to _____
- When life gets too hard I _____
- To be happy I need _____
- I would do anything for _____
- I often wonder why _____
- It embarrasses me to _____
- I cannot decide _____

Please describe the current problem, as you understand it. _____

What have you done about it? _____

Is there any other information we should know? _____
