



## Client Information Form

### GENERAL INFORMATION

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

### **Responsible Party (if different from above)**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

### REFERRAL SOURCE

How did you hear about us? \_\_\_\_\_

If you were referred to us by a specific person, do we have your permission to thank them?  Yes  No

Name of Referral source (if applicable): \_\_\_\_\_

Preferred? Leave Message?  
HOME PHONE: \_\_\_\_\_  Y  N  CELL  
PHONE: \_\_\_\_\_  Y  N  WORK  
PHONE: \_\_\_\_\_  Y  N  EMAIL  
ADDRESS: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_  MALE  FEMALE  
EMPLOYER \_\_\_\_\_  
JOB TITLE/POSITION \_\_\_\_\_  
HIGHEST EDUCATION LEVEL ATTAINED, WHERE \_\_\_\_\_

MARITAL STATUS  Single  Married  Divorced  Separated  Widowed  Committed Relationship

RACIAL IDENTITY  American Indian  Asian  African-American  Caucasian  Hispanic  Middle Eastern

RELIGIOUS/DENOMINATIONAL Preference (if applicable): \_\_\_\_\_

MEMBER OF A CHURCH? Yes\_\_\_ No\_\_\_ If Yes, WHAT CHURCH \_\_\_\_\_

Name of Pastor, Minister, or member of the Clergy \_\_\_\_\_

**EMERGENCY CONTACT**

\_\_\_\_\_  
Name Contact # Relationship to you

**SPOUSE** # of Years Together: \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

EMPLOYER \_\_\_\_\_

JOB TITLE/POSITION \_\_\_\_\_

HIGHEST EDUCATION LEVEL ATTAINED \_\_\_\_\_

EMAIL \_\_\_\_\_

**CHILDREN**

Name	Sex	Age	Additional Pertinent Information (if any)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HOUSEHOLD'S TOTAL INCOME**

\_\_\_ \$0-60,000 \_\_\_ \$60-79,999 \_\_\_ \$98-99,999 \_\_\_ \$100,000 or more

**PRESENTING PROBLEM**

What brings you to counseling at this time?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Have you (or your family members) ever been involved in counseling? Yes No  
If yes, with whom? \_\_\_\_\_ When? \_\_\_\_\_  
Reason(s): \_\_\_\_\_  
Are you in treatment with another counselor at this time? Yes No  
If yes, with whom? \_\_\_\_\_ Reason \_\_\_\_\_  
Have you ever been admitted to an inpatient or outpatient treatment program? Yes No  
If so, where? \_\_\_\_\_ Dates of treatment \_\_\_\_\_  
Reason for treatment \_\_\_\_\_

**MEDICAL CONTACT/HEALTH CONDITIONS**

Name of Primary Physician \_\_\_\_\_  
Phone \_\_\_\_\_  
Date of Last Physical \_\_\_\_\_  
Date of Last Visit \_\_\_\_\_  
Known diagnoses (physical and/or Psychological) \_\_\_\_\_  
Name of Psychiatrist (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

Please list all prescribed medications (Medication, Dosage, Frequency, & Name of Prescribing Physician)

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Check which of the following you use, and please note the amount and frequency of each:

- Caffeine       Coffee       Sodas       Other drinks       Pills/Supplements  
 Alcohol/Adult Beverages \_\_\_\_\_  
 Tobacco \_\_\_\_\_

**FUTURE APPOINTMENTS**

**Should we need to contact you regarding your future appointments, please indicate how we may do this if you are not available when we call. Initial all that apply.**

- \_\_\_\_\_ Leave appointment time on answering machine/voicemail  
\_\_\_\_\_ If no answering machine, leave appointment time with \_\_\_\_\_  
\_\_\_\_\_ Leave a message with callback number requesting you contact Restore Ministries  
\_\_\_\_\_ Email or Text appointment information

## **Informed Consent of Client**

Confidentiality: All information disclosed within a counseling session is confidential and may not be revealed without your written permission, except for the purpose of supervision. If you choose to have Restore Ministries keep any other individual apprised of your progress in counseling, it will be necessary to complete a “Release of Information” form that will be kept on file. Without a properly executed release, everything about your visit will be held in strictest confidence with the exception of the following circumstances: when a client intends to take harmful, dangerous, or criminal action against themselves or another individual; when a client or their family is likely to suffer threats, or the results, or harmful behavior; or where there is a reasonable suspicion of the abuse of elderly persons or the children under the age of eighteen.

If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/adolescent, therapist/adolescent, and therapist/parent for their particular situation. It may be imperative to my therapeutic relationship with an adolescent not to reveal the information disclosed to me in session to their parents/guardians. It is important that all parties involved in the therapeutic process are clear on our communication expectations.

If I should find myself in a social setting where you are present (e.g., grocery store, restaurant, social event), I will respect your privacy by not initiating contact or seeking to engage you in a conversation unless initiated by you. Should a colleague, friend, or family member accompany me, I will not introduce them to you.

**Cancellation Policy: Your session is reserved for you. In the event that you will be unable to keep an appointment, please notify me NO LATER THAN 48 HOURS IN ADVANCE. In the absence of your notification, you will be charged for the missed session. Restore counselors request that all clients provide a credit card number to keep on file in the case of missed appointments without notification. This information is kept in a confidential file that is locked at all times. If you “no show” the cancellation charges will be charged to your card.**

Referrals: I realize that I am not able to provide appropriate treatment for all of the conditions that clients may have. For this reason, you and /or I may believe that a referral is needed. In that case, I will provide you with some alternatives including programs and or people who may be able to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

In Case of an Emergency: Our office number is not an emergency number and Restore Ministries does not offer 24 hours crisis coverage. Therefore, the following procedure is to be followed if you experience a crisis:

Call 911 if you are in immediate danger; or go to the nearest emergency room. You can also call the Birmingham Crisis Center (205) 323-7777

Email, Text Messaging and Cell Phones: Email, cell phones, and text messaging can be helpful and efficient ways to communicate between sessions. However it is important for you to be aware that there is always a certain degree of risk or breach of privacy when communicating this way. You may communicate with me via email/text to schedule

or reschedule sessions. You may also email me between sessions – however please realize I will not address a new issue via email. I will wait until our next session to discuss anything sent in an email. Please note that any phone calls made between sessions that last more than 10 minutes will be charged at half of your hourly rate.

Payment: Restore Ministries is a non-profit organization (501c3) that receives contributions to scholarship our sliding fee scale. You may pay through cash, check (please make out your check to Restore Ministries), or credit card. A receipt will be provided upon request. If you are unable to contribute the amount indicated below, please bring that to our attention so we can work with you. Payment is due at the end of each session.

**Sliding Scale for Services Provided**

<b>INCOME</b>	<b>\$0-\$65,000</b>	<b>\$66,000-\$85,000</b>	<b>\$86,000-\$105,000</b>	<b>\$106,000 or above</b>
<b>Payment</b>	<b>\$65</b>	<b>\$80</b>	<b>\$100</b>	<b>\$115</b>

Waive Right to Subpoena: In order to protect and enhance our communication, you and the information you and/or your children provide to me during our sessions, I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your children provide during a session is considered privileged.

If you choose to subpoena me regardless of this statement please understand fees for depositions and court appearances are billed at \$100 per hour door to door.

My signature below acknowledges that I have read and been able to ask questions regarding the above information.

Signature of Counselee/Client \_\_\_\_\_ Date \_\_\_\_\_

HIPAA: Copies may be downloaded on [www.restore-ministries.org](http://www.restore-ministries.org). I further attest that Restore Ministries has provided me with a copy of the Notice of Privacy Practices.

Signature of client \_\_\_\_\_

Printed Name of client \_\_\_\_\_