

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street Address \_\_\_\_\_ Phone (h) \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Phone (w) \_\_\_\_\_  
 Email address \_\_\_\_\_ Phone (cell) \_\_\_\_\_  
 For confidentiality, when and where do you prefer to be reached? \_\_\_\_\_

Current Marital status: Single \_\_\_\_\_ Engaged \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_  
 Date of Current Marriage/Separation: \_\_\_\_\_ Number of Marriages: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Number of Children and ages: \_\_\_\_\_  
 Presently living with: Parents \_\_\_\_\_ Spouse \_\_\_\_\_ Roommate \_\_\_\_\_ Alone \_\_\_\_\_ Other \_\_\_\_\_  
 Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to you \_\_\_\_\_

Who referred you or how did you hear about us? \_\_\_\_\_ Counselor Preference (if none, leave blank): \_\_\_\_\_

**Please list specific days/times for your appointment availability:**

Monday  morning  afternoon  evening  
 Tuesday  morning  afternoon  evening  
 Wednesday  morning  afternoon  evening  
 Thursday  morning  afternoon  evening  
 Friday  morning  afternoon  evening  
 (Limited Friday evening appts. available)

**What type of counseling are you seeking? Please select one:**

Type	DESCRIPTION	FORMS REQUIRED
<input type="checkbox"/> INDIVIDUAL	1-on-1 counseling	1 intake form
<input type="checkbox"/> FAMILY	2 or more family members	1 intake form per person over 18 yrs. old
<input type="checkbox"/> RELATIONSHIP	Couples who are dating	1 intake form per person (total of 2 forms)
<input type="checkbox"/> PRE-MARITAL	Couples engaged or considering it	1 intake form per person (total of 2 forms)
<input type="checkbox"/> MARITAL	Couples needing marital guidance	1 intake form per person (total of 2 forms)

**REASONS FOR SEEKING HELP**

What concerns have led you to pursue counseling? \_\_\_\_\_

Where are your concerns causing the most problems for you? Check all that apply:  Home  Work  Marriage  Other Relationships  God

When did your present concern begin to be a problem for you? \_\_\_\_\_

Have any concerns about you been identified by others? \_\_\_\_\_

Please rate the severity of your present concerns on the following scale. Check one:  Mild  Moderate  Severe  Totally Incapacitating

Please indicate which of the following areas are currently problems for you. Check all that apply:

- Under too much pressure/feeling stressed
- Excessive anxiety or worry
- Feeling lonely
- Angry feelings
- Concerns about finances
- Feeling "numb" or cut off from emotions
- Angry outbursts
- Excessive fear of specific places/objects
- Difficulty making friends
- Feeling as if you'd be better off dead
- Feeling manipulated or controlled by others
- Difficulty making decisions
- Loss of interest in sexual relationships
- Feeling sexually attracted to members of your own sex
- Concerns about physical health
- Blackouts or temporary of loss of memory
- Insomnia (no sleep) or Hypersomnia (sleep all the time)
- Loss of appetite/increased appetite
- Lacking self-confidence
- Issues with food and/or weight
- Abuse of alcohol and/or non-prescription drugs
- Delusions
- Feeling distant from God
- Hallucinations
- Inability to concentrate while at school/work
- Crying spells
- Nightmares
- Loss of interest in usual activities/lack of motivation
- Obsessions or compulsions with specific activities
- Inability to control thoughts
- Feeling trapped in rooms/buildings
- Hearing voices
- Feeling that people are "out to get you" or that you're being watched

**MEDICAL/HEALTH INFORMATION**

How would you rate your current physical health?  Excellent  Good  Fair  Poor Date of last physical examination: \_\_\_/\_\_\_/\_\_\_

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems)  Yes  No

If yes, please explain: \_\_\_\_\_

<b>MEDICATION(S) Over-the-counter or prescription</b>	<b>DOSAGE</b>

Previous hospitalizations for medical reasons: Date \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Reason \_\_\_\_\_

Have you ever been hospitalized for psychiatric purposes?  Yes  No

If yes, please explain including name of hospital, location and dates:  
\_\_\_\_\_

Permission to contact previous counselor:  Yes  No

Please list names of any previous counselors or therapists, including dates and contact number:  
\_\_\_\_\_

How do you feel about the results of your previous counseling?  
\_\_\_\_\_

What do you hope to gain from counseling? \_\_\_\_\_

**OCCUPATIONAL/EDUCATIONAL INFORMATION**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Present annual income: \$ \_\_\_\_\_

If Currently a Student: Field of Study \_\_\_\_\_ Part-Time  Full-time

Institution, University or College \_\_\_\_\_

**RELIGIOUS BACKGROUND (optional)**

Do you believe in God?  Yes  No Religious preference: \_\_\_\_\_

What church do you currently attend? \_\_\_\_\_ Are you a member of Redeemer Presbyterian Church?  Yes  No

How much influence does your religion have on your day-to-day activity? \_\_\_\_\_

**CONSENT OF RELEASE OF INFORMATION**

In the event that a Redeemer Counselor is not available to address the needs of the client, due to scheduling or otherwise, Redeemer Counseling Services is authorized to release all intake information to a referred therapist. The consent for release of information avoids any delays in beginning therapy and insures that the client receives appropriate care.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

# COUNSELING 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 included with the intake form in order to begin counseling.

## Description of Counseling

Redeemer's counseling philosophy is wholistic in that three interrelated perspectives are explored in therapy: the Existential (the person), the Situational (his/her world), and the Normative (his/her God). Although counselors at Redeemer are guided by a Christian worldview, your counselor will be sensitive to your religious/cultural differences and perspectives. Based on your counseling needs, you may be advised to take appropriate tests/inventories or seek medical treatment to facilitate the counseling process. RCS adheres to the Code of Ethics prescribed by the American Association of Marriage and Family Therapy and American Christian Counseling Association. To view our code of ethics, log on to [www.aamft.org](http://www.aamft.org) and to [www.aacc.net](http://www.aacc.net).

## Referral Policy/Disclaimer

Clients will be referred outside of RCS when treatment required is beyond the scope of care available at RCS. Though Redeemer Counseling Services strives to be responsible and professional in the referral procedure, it is your full right and responsibility to select the professional of your choice. Furthermore, Redeemer is not liable for any services provided or not provided by the referred professional.

## Counseling Fees

The fee for a 50-minute session is \$150.00. A sliding scale fee structure is available for those with a qualifying income level. Use of the sliding scale must be accompanied with verification of income, such as the most recent tax return. Payment is due at the beginning or the end of each session and accounts must be kept current in order to continue counseling at RCS. Cash or checks are accepted forms of payment (checks made payable to "Redeemer Presbyterian Church.")

\*\*\*Please note that we are unable to accept insurance.\*\*\*

## Confidentiality

To release information without your consent would violate commonly accepted codes of counseling ethics. There are situations, however, in which we are required by law to reveal information without your consent. Please see the "**Notice of Policies and Practices to Protect the Privacy of Your Health Information**" given to you at your initial session for details. All counselors at RCS participate in regular peer supervision. During this supervision your personal identity will be concealed. The purpose of supervision is to insure quality of care received at RCS.

## Rights As a Client

1. You are entitled to information about any procedures, methods of counseling, techniques and possible duration of therapy.
2. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.
3. You have the right to expect confidentiality within the limits described in the Notice of Policies and Practices to Protect the Privacy of Your Health Information.
4. You have the right to request in writing the release of your records to any person or agency.
5. You have the right to authorize your counselor to consult with another professional about your therapy in writing.
6. You have the right to file a grievance in writing with the Director of RCS if you have concerns that your rights as a client have been violated.

## Mediation & Arbitration

All disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and client. The cost of such mediation, if any, shall be split equally.

## Cancellation Policy

Redeemer Counseling Services requests that you notify your Counselor at least **48 hours** before your scheduled appointment time if you need to cancel a session. Failure to do so will result in charges for the missed appointment. This charge should be paid before or at the time of your next appointment to continue in the counseling relationship. Exceptions are for sudden illnesses and emergencies only.

## Contacting Your Counselor

For scheduling and canceling your appointments, you must contact your therapist directly by dialing the RCS main number (212) 370-0475 and then the extension number of your counselor. For general information, please contact the reception desk during regular offices hours of 9:00 AM-5:00 PM at ext. 131. For emergencies after-hours, please contact 911, your local emergency room, or 1-800-LIFENET.

If these guidelines are acceptable to you, please sign below:

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

(Required if under the age of 18)

# Application for Reduced Fee

**\*\*\*Please attach a copy of a paycheck stub and/or other income information to this application otherwise a reduced fee will not be considered.\*\*\***

NAME \_\_\_\_\_ DATE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Numbers of hours/weeks \_\_\_\_\_

IF CURRENTLY A STUDENT, please fill out the below information:

School \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

As a student, how are you financially supported? Self-supported \_\_\_ Parents \_\_\_ Other (explain): \_\_\_

\_\_\_\_\_

Who will be responsible for billing purposes? \_\_\_\_\_

## INCOME:

Did you file a tax return for the most recent year? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, explain: \_\_\_\_\_

\_\_\_\_\_

Please enter **Adjusted Gross income** of most recent tax return: \$ \_\_\_\_\_ Year \_\_\_\_\_

Single Return \_\_\_\_\_ Joint Return \_\_\_\_\_

Has your employment changed since your last tax return? If yes, explain \_\_\_\_\_

\_\_\_\_\_

Has your income changed since your last tax return? If yes, explain \_\_\_\_\_

\_\_\_\_\_

Is your income from sources other than or in addition to wages or salaries? Yes \_\_\_ No \_\_\_

Average monthly wages or salaries \$ \_\_\_\_\_

Other (please itemize on back sheet) \$ \_\_\_\_\_

**MONTHLY TOTAL** \$ \_\_\_\_\_