**Counseling Agreement**

At **(Name of Church)**, we strongly believe the power of faith in Jesus Christ can lead to emotional healing and well-being. We believe Christ can bring peace in the power of the Holy Spirit into the lives of those who confess their faith. For those who face problems and crises in their lives, **(Name of Church)** provides guidance, care, and support in prayer.

To assure a mutual understanding of the help offered by **(Name of Church)** in this time of need, we ask that you review and sign this Counseling Agreement, which spells out the terms of this assistance.

By signing this Counseling Agreement, I understand and acknowledge that:

1. The counseling provided is Biblical, not professional.
2. The pastor’s counseling is not professional in psychological counseling, psychiatric therapy, or marriage and family counseling or therapy, and is not licensed by the state as a counselor, social worker, or therapist.
3. I agree not to sue the church for any expenses or damages that result from any of the pastor’s counseling services.
4. Both the pastor and I will maintain the confidentiality of our communication.
5. I understand otherwise confidential communications may be disclosed by the pastor to appropriate state law enforcement authorities where required by law.

I also understand that the pastor will refer me for professional counseling to a professional medical or psychiatric counselor with specialized training if the pastor determines my problems extend beyond his ability to help.

I further understand that the pastor will set a limit on the number of counseling sessions to no more than three (3) hour-long periods, and I agree to abide by this limitation.

Finally, I understand that there may be additional specific terms to this Counseling Agreement that will be appended to this document.

*Pastor Name of Person in Counseling*

Date:

# Counseling Session Record:

1.

2.

3.

**(Name of Church) Counseling Ministry**

**Adult Intake Form** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_ Church member? Yes No If so, how long?

Who referred you to us for counseling?

Marital Status: Never Married Single Married Separated

 Divorced Widowed Living Together

If married, how long? Spouse:

If applicable, please rate the extent of your current marital satisfaction on a scale of 1 to 10:

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

If divorced, separated, or widowed, when?

If you’ve previously been married, how many times?

If divorced, how would you describe your relationship with your ex-spouse?

What is the current custody situation with the children?

Please list all of your children (and step-children) and indicate whether they live with you at home:

Name Age Home? Name Age Home?

How would you describe the relationship with your children?

What is your level of education?

What is your occupation?

What is your current employment situation?

Why are you seeking help at this time?

How long have you been dealing with this issue?

How is this impacting your life:

At home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In other ways?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in counseling before? Yes No

If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why did the counseling end?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you satisfied with the results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal for this counseling? What do you hope it will accomplish?

Please complete this thought: ***My counseling will be successful if I...***

Do you consume alcohol? Yes No

If yes, how much and how often?

Do you ever become intoxicated? Yes No

Have you ever used illicit drugs? Yes No

If yes, what, when, and for how long?

If you use prescription or over-the-counter medication, have you ever used more than the prescribed amount? Yes No

Have you ever had a problem with drug or alcohol abuse? Yes No

If yes (include prescription drugs), please describe:

Have you had any previous treatment for alcohol/drug use? Yes No

If you have, please describe:

Do any members of your family have a history of drug and/or alcohol abuse?
 Yes No Not sure

If yes, please explain:

Do you have a family history of depression or any other emotional problems?
 Yes No Not sure

If yes, please describe and indicate how the problem was addressed:

Have you ever experienced any kind of physical, sexual, and/or emotional abuse?
 Yes No Not sure

If yes, what type of abuse have you experienced?

When did/does it occur?

Has the abuse ever been disclosed and/or reported? Yes No

If yes, how?

What type of legal action, if any, was taken regarding the abuse?

How does the abuse affect you presently?

Have you ever thought about suicide? Yes No

If yes, when?

Why?

Did you take any steps to harm yourself? Yes No

If yes, what did you do?

Did you receive any treatment? Yes No

Have you ever been hospitalized for any emotional reasons? Yes No

If you have received psychiatric treatment, please describe:

Please note any pertinent medical history:

Have you been under the care of a psychiatrist? Yes No

If you are currently on any medications, please complete below:

Medication Dosage Purpose Physician

Do you consider yourself to be a Christian? Yes No Not sure

If yes, please briefly describe how you became one:

Do you belong to a church? Yes No

If your membership is with a church other than **(Name of Church)**, which one is it?

How often would you say you attend church in a typical month?

 I usually don’t attend

 1 – 2 times per month

 3 – 4 times per month

 5 – 6 times per month

 7 or more times per month