

Start Date: _____



Initials: _____

Counseling Intake Form

Name: _____ **DOB (MM/DD/YYYY):** _____

Contact Phone: _____ **Email:** _____

Mailing address: _____

District: _____ **City:** _____ **Postal code:** _____

Informed Consent:

Therapy is a voluntary relationship that works in part because of clearly defined rights and responsibilities held by each person.

I understand that I may be asked to do certain “homework exercises” such as reading, praying, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

Confidentiality

I understand that I have a right to confidentiality in the therapy process.

The following are legal exceptions to your right to confidentiality.

1. Threat to harm another person - The therapist must attempt to inform the person and the police to protect intended victim.
2. Abuse or neglect of a child or vulnerable adult.
3. Imminent threat to your life. Your therapist may legally break confidentiality and call the police. Your therapist will work with you to protect your safety and call on other resources if necessary.

Further exception. If a couple is pursuing couples counseling, but attends sessions individually, the content of these sessions may be addressed in combined sessions, as the couple remains the “client”.

Record-keeping

I understand that the therapist will keep brief records of each session noting the session dates, the topics discussed, interventions, therapist impressions, and therapy goals.

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Other Rights

I have the right to ask the therapist questions about anything that happens in the sessions. I understand that the therapy process is voluntary. I can request a referral to another professional at any time in the process without loss of benefit.

Emergencies

I understand that the China Hope Center or its staff do not have 24 hour emergency or “on call” coverage. *If I experience a psychiatric emergency, I should go to the nearest hospital emergency room rather than waiting for someone at the CHC to call me back.*

Fees

I understand that I will pay in full for appointments not canceled with 24 hours notice. The rate is 700 RMB/hour.

(Client signature and date)

(Therapist signature and date)

As your therapist/counselor, you honor me by sharing your life and growth with me. I will not hide myself behind silence or position and will have high regard for you as a person. I will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance.

I will keep a holistic perspective in our work together because I believe that the Physical, Spiritual, and Soul (mind, will, emotions) all work together to form the wholly healthy person.

You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that.

PRESENT CONDITION

Emotional Issues:

- Depression
- Anxiety
- Panic Attacks
- Manic/Depression
- Obsessions
- Suicide attempts
- Violent episodes
- Psychotic episodes
- Phobia/fear(s)
- Anger/explosive

Explain _____

Feelings Checklist:

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> helpless | <input type="checkbox"/> sad | <input type="checkbox"/> relaxed |
| <input type="checkbox"/> depressed | <input type="checkbox"/> stressed | <input type="checkbox"/> happy |
| <input type="checkbox"/> shameful | <input type="checkbox"/> numb | <input type="checkbox"/> excited |
| <input type="checkbox"/> angry | <input type="checkbox"/> anxious | <input type="checkbox"/> hopeful |
| <input type="checkbox"/> guilty | <input type="checkbox"/> out of control | <input type="checkbox"/> feelings of inferiority |
| <input type="checkbox"/> hopeless | <input type="checkbox"/> controlled | <input type="checkbox"/> mood shifts |
| <input type="checkbox"/> lonely | <input type="checkbox"/> afraid | <input type="checkbox"/> other _____ |

Thoughts Checklist:

- | | | |
|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> confused | <input type="checkbox"/> confident | <input type="checkbox"/> disorganized |
| <input type="checkbox"/> unintelligent | <input type="checkbox"/> worthwhile | <input type="checkbox"/> paranoid |
| <input type="checkbox"/> worthless | <input type="checkbox"/> homicidal | <input type="checkbox"/> suicidal |
| <input type="checkbox"/> unmotivated | <input type="checkbox"/> racing | <input type="checkbox"/> sensitive |
| <input type="checkbox"/> unattractive | <input type="checkbox"/> obsessive | <input type="checkbox"/> honest |
| <input type="checkbox"/> unlovable | <input type="checkbox"/> distracted | <input type="checkbox"/> other _____ |

Behavior Checklist:

- | | | |
|--|--|--|
| <input type="checkbox"/> procrastinating | <input type="checkbox"/> compulsivity | <input type="checkbox"/> alcohol use |
| <input type="checkbox"/> attempting suicide | <input type="checkbox"/> sexual problems | <input type="checkbox"/> exercising regularly |
| <input type="checkbox"/> eating (less or more) | <input type="checkbox"/> acting out sexually | <input type="checkbox"/> good nutrition |
| <input type="checkbox"/> poor concentration | <input type="checkbox"/> acting aggressively | <input type="checkbox"/> poor nutrition |
| <input type="checkbox"/> crying | <input type="checkbox"/> disorganization | <input type="checkbox"/> good to yourself |
| <input type="checkbox"/> withdrawing socially | <input type="checkbox"/> impulsivity | <input type="checkbox"/> socializing |
| <input type="checkbox"/> skipping classes/work | <input type="checkbox"/> recklessness | <input type="checkbox"/> parent/child conflict |
| <input type="checkbox"/> binge drinking | <input type="checkbox"/> irritability | <input type="checkbox"/> lack of ambition/goals |
| <input type="checkbox"/> injuring self | <input type="checkbox"/> marital conflict | <input type="checkbox"/> poor peer relationships |
| <input type="checkbox"/> lying | <input type="checkbox"/> passivity | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> financial concerns | <input type="checkbox"/> drug use | <input type="checkbox"/> other _____ |

Briefly describe your reason for seeking counseling.

Have you or any member of your family experienced any of the following? (check all that apply)

Addictions: Alcohol Gambling Drugs Sex/pornography Food/eating Other _____

Explain _____

Abuse:

Have you ever experienced or been witness to any abuse?

Physical Emotional Sexual Spiritual

Is there anything more you would like to share regarding the abuse? _____

Physical History (please be accurate)

General Health (Excellent, good, fair, or poor) _____

Are you now under a doctor's care? _____ If yes, name of doctor _____

Reason for doctor's care _____

Are you taking any medication? _____ If yes, what kind? _____

Reason for medication _____ Last medical examination _____

Any previous therapy/counseling? _____ If yes, describe, when, where, how long, what for?

Have you ever been hospitalized for a mental issue? _____

What do you hope to achieve with therapy? _____

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Work History

Occupation _____ How long? _____

If presently unemployed, describe the situation _____

Family Information

Where were you born? _____ How long did you live there? _____

Ethnic Identity _____ How long have you lived in Beijing? _____

Languages spoken: _____

Marital Status _____ #of marriages? _____ Length of marriage(s) _____ Spouse's name _____

Living with a partner? _____ How long? _____ Partner's Name _____

Children: How many? _____ Ages? _____

Relationship with father: _____

Relationship with mother: _____

Parents Relationship: Happy/Unstable/Divorced/It's Complicated (Circle One) Explain:

Siblings: How many? _____ Birth Order? _____ Any step-parents? _____ If yes, describe when and your relationship: _____

If raised by someone other than your birth parents, describe the situation in some detail

Spiritual History

Religious upbringing? _____ Presently do you attend church? _____

Is this an important part of your life? _____ Why/why not? _____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

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