New Client – Family Counseling Intake Form

Mount Olivet Counseling Service
1804 West 50th St. Minneapolis, MN 55419
5000 Logan Ave. So., Minneapolis, MN 55419
7150 Rolling Acres Road, Victoria, MN 55386 - 612-927-7335

Welcome! Please provide the following information. Please complete this form together if possible. The information you provide here is protected as confidential information.

Name: _____ Date of Birth_____ Age: _____ Today's Date: _____
Name: _____ Date of Birth_____ Age: _____
Name: _____ Date of Birth_____ Age: _____
Name: _____ Date of Birth_____ Age: _____
Name: _____ Date of Birth_____ Age: _____

Address of person financially responsible: _____ City_____
State _____ Zip _____
Primary phone: _____ name: _____ May we leave a message? ____yes __no
Secondary phone: _____name: _____ May we leave a message? ____ yes __no

Email/s: _____ _____ May we leave a message? ___yes ___no

Emergency Contact Person_____Phone_____ Relationship?_____OK to contact? Yes__ No__

Members of Mt. Olivet Church? Yes [ ] No [ ]
How did you hear about Mt Olivet Counseling Service?_____
Have any of you previously seen a counselor at Mt. Olivet Counseling Service? [ ] Yes [ ] No If so, when?_____

Relationship Status of parents of this family: (check all that apply)
( ) Long term relationship for _____ years
( ) Married for _____ years
( ) Separated after a marriage/relationship of _____ years
( ) Prior relationship/marriages for___ one or ___ both parties? Please list approximate dates: _____

_____

Your Family Information:
First name, date of birth, and gender of any children or step-children in the family:
1)_____ Age__ d.o.b____ 2) _____ Age__ d.o.b____ 3)_____
age ___d.o.b._____ 4)_____ age__ d.o.b_____ 5)_____ age __d.ob. ____
6)_____age __ d.o.b._____
Are there any co-parents or step-parents involved in your children's care? [ ] Yes [ ] No
If yes, names of co-parents or step-parents:
_____
_____

Mental Health History: Partner 1: _____
Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
_____	_____	_____
_____	_____	_____
_____	_____	_____

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____

Have you ever been hospitalized for psychiatric reasons? ( ) Yes ( ) No
Is there a history of mental illness in your family? ( ) Yes ( ) No
If yes, please elaborate____
____

If yes, please explain ____

Mental Health History: Partner 2: _____________________________________
Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
______________________	_______________	_________________
______________________	_______________	_________________
______________________	_______________	_________________

____

Have you ever been hospitalized for psychiatric reasons? ( ) Yes ( ) No
Is there a history of mental illness in your family? ( ) Yes ( ) No
If yes, please elaborate____
____

If yes, please explain ____

Relevant Mental Health History: Other participating family members:
Name: ______________________
Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
______________________	_______________	_________________
______________________	_______________	_________________

Name: ______________________
Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
______________________	_______________	_________________
______________________	_______________	_________________

Name: ______________________
Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
______________________	_______________	_________________
______________________	_______________	_________________

____

Name: ______________________
Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no
If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
______________________	_______________	_________________

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_____ _____ _____
_____ _____ _____
_____

What is your family's general **faith/spirituality history**?_____

Significant Cultural History or issues you feel are important for your therapist to know:

_____

Family/Relationship Strengths: _____

_____

_____

What kinds of support systems (connections) do you have in your life?_____

_____

_____

What issues challenges your family relationship the most right now, or led to your decision to seek couples/ family counseling? _____

_____

_____

What solutions have you tried to cope with these issues? _____

_____

_____

What do you hope to gain from couples/ family counseling (changes sought)? _____

_____

_____

Legal or Financial Issues: Please list any that are affecting your family right now, or which have had a significant impact on you in the past?_____

_____

_____

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Family Relationship Concerns: (Please check any relationship concerns you currently have)

( ) Fighting/anger	( ) Traumatic events
( ) Separation/divorce	( ) Conflict with relatives and/or friends
( ) Sexual/gender identity conflicts	( ) Alcohol use
( ) Lack of honesty	( ) Drug use
( ) Sexual abuse	( ) Other Addictions_____
( ) Educational problems	( ) Grief/loss
( ) Disagreement about parenting	( ) Financial difficulties
( ) Blended family issues	( ) Disagreement about role of social media
( ) Emotional Abuse	( ) Physical health issues in family
( ) Mental health concerns in family	( ) Other:_____

Is there anything else you think would be helpful for your counselor to know?

_____

_____

Please read the following information about our program, and sign the last two pages.

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INFORMATION FOR CLIENTS & INFORMED CONSENT FOR FAMILY THERAPY

APPOINTMENTS AND SCHEDULING:

All appointments are scheduled with our Office Manager, Molly Pach, by calling 612-927-7335 or emailing mpach@mtolivetcounseling.org. Press 10 to leave her a voice mail. It is your responsibility to schedule your appointments and keep them. Please be alert to how many appointments remain in your series and discuss your scheduling options as needed with your clinician. Psychiatric consultations are scheduled one appointment at a time. **We are not a crisis center.** The telephone is answered Monday through Friday, usually prior to 12:00pm. If you are in crisis or believe a crisis may arise, please call 911. We do offer some evening appointments. Sessions are 50 minutes long. If a client is late for their appointment, the appointment time will not be adjusted. Please contact Molly 24 hours in advance of the scheduled appointment time, if you need to cancel, so that your time can be given to someone waiting for an appointment. **A no-show, or a cancellation later than 24 hours prior to the scheduled appointment will be charged the session fee.** We reserve the right to decline scheduling of future appointments if there is a pattern of cancellations or no-shows.

FEES

Fees for members of Mount Olivet are $50.00 per session for counseling and medication management services. Fees for non-members are $100.00 per session. We do not work with third party payers/insurance companies. We do not send out monthly bills or keep record of payments. You are asked to pay for each session as it occurs unless you make other arrangements, and to ask for a receipt if you believe you will need one.

E-MAIL & SOCIAL NETWORKING POLICIES

If you send an email, we will generally only respond for purposes of scheduling or appointment reminders. Be aware that all e-mails are retained in the logs of your and Mt. Olivet Counseling Service's Internet service providers. While it may be unlikely that someone reads these, they are available to be read by the system administrator of the Internet service provider. You should also know that any e-mails we receive from you become a part of your legal and therapy records**. Please do not use SMS (texting), Twitter, Facebook, or LinkedIn to contact your therapist. These sites are not secure**. We do not accept friend requests or contact requests from current or former clients on any social networking site, since adding clients as friends or contacts can compromise your confidentiality and privacy. It may also blur the boundaries of our therapeutic relationship. If you have any questions about this, please ask your therapist when you meet.

CONFIDENTIALITY:

The fact that you are a client ensures that all information about you, as well as the content of your sessions and phone conversations, will be held in strict confidence with the following possible exceptions:

- If you sign a Consent for Release of Information form, you authorize us to communicate specified information about you with one or more specified professionals or agencies outside of this office;
- In order to ensure the best possible care, the intern and professional staff meet regularly to consult and collaborate regarding client care;
- If your records are subpoenaed by signature of a judge, we are required to release them to the court; the therapist will not agree to testify in legal matters related or unrelated to therapy.
    - If you are using, mood-altering drugs including alcohol, while pregnant, we are required to report this information;

- If you are a minor (under age 18), your parents have access to your records, unless:
  - You are emancipated, (living away from home and paying your own way) you are pregnant, or
  - You are in danger of harm from one or both of your parents;
- If you have previously had inappropriate sexual contact from any health care provider, and if you reveal the name of such provider, we are mandated to report this information to the appropriate licensing board;
- In the course of your session, if we have reason to suspect the abuse of a child or of a vulnerable adult, we are required by law to file a report of the alleged abuse to the appropriate county or state agencies. This report is required whether the alleged abuse occurs within your family or outside of it;
- In the course of your sessions, if, after careful and thoughtful consideration, we come to believe that there is a clear and imminent danger of your physically harming yourself or another person, we will take steps to prevent such potential harm, steps which will violate your confidentiality.
- Making threatening statements of harm to any Mt. Olivet Counseling Service staff person or their family, will result in termination of therapy and notification of proper authorities.

PHILOSOPHY:
In most situations, the therapist's role is that of a consultant. The therapist's job is to help you think about what your problems are and explore possible solutions to your problems. The therapist will listen to you and give feedback about what they hear and what the therapist thinks your options are. Although the therapist will explore options with you, rarely will the therapist tell you what to do, because the decision and the responsibility to make changes in your life needs to be yours. Your job is to be more open and honest about yourself in therapy, than you are in social relationships and to be committed to the process of therapy. You are responsible for deciding what to talk about in each session and deciding what your goals are.

During the course of therapy, the therapist is likely to draw on various psychological approaches which stem from the nature of the problem and the assessment of what will best benefit you. If you are not getting what you want, you have the right to ask for other treatments or for a referral to other professionals. If the therapist believes they are not being helpful to you, the therapist also has an obligation to help you find someone who might be more helpful. You may terminate treatment at any time.

Referrals: We reserve the right to refer a client to a more appropriate type of therapy with other therapists if we assess that your needs are not likely to be best served by our staff.

Referrals to our Psychiatrist or Internist at Mt. Olivet Counseling: Clients are referred to our psychiatrist or internist only internally while maintaining a counseling relationship with one of our therapists.

LEGAL WAIVER: The therapist's role is for the sole purpose of the improvement of psychological and relational distress. The process of therapy depends on trust and openness during therapy sessions. Therefore it is understood by all parties that they are not to use information given to the therapist during therapy sessions, for any legal purposes. No attempt shall be made to subpoena the therapist's testimony or records to be presented in a deposition or court hearing of any kind, for any reason such as a divorce case. **If the therapist is required to appear as a witness, the party responsible for his/her participation agrees to reimburse him/her or MTOCS at the rate of $200 per hour for the time spent traveling, preparing reports or any other case related costs.**

LIMITATION ON CONFIDENTIALITY WHEN PROVIDING THERAPY TO COUPLES/FAMILIES:
There are different expectations and limits about confidentiality in relational therapy than there are in individual therapy. When the therapist agrees to treat a couple or family, the therapist considers the relationship

between the couple/family members to be the client and hence the couple/family is the client. For instance, if there is a request for the treatment records of the couple, the therapist will need the authorization of both/all members before releasing confidential information. Also, if the therapist's records are subpoenaed, the therapist will assert the psychotherapist-patient privilege on behalf of the couple/family, not just an individual.

During the course of work with a couple/family, the therapist may see certain individuals alone for one or more sessions. These sessions are a part of the therapy for the couple/family, unless otherwise indicated. Generally, these sessions are confidential in the sense that the therapist will not release any confidential information to a third party unless required by law to do so or unless the therapist has your written authorization. Since individual sessions in the context of couple/family therapy can and should be considered a part of the treatment of the couple/family, the therapist will also seek the authorization of the other individual/s before releasing confidential information to a third party.

However, be aware that the therapist may need to share information learned in an individual session with the members of the family/couple, if determined in the best judgment of the therapist that it is important to share the information to effectively serve the therapy of the family/couple. The therapist will use their best judgment about such disclosures and will also, if appropriate, first give the individual the opportunity to make the disclosure. **Thus, if it is important to you to talk about matters which you don't want to share with anyone else, you might want to consult with a different therapist who can treat you separately.**

POSSIBLE RISKS OF THERAPY: During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in experiencing discomfort or strong feelings of anger, sadness, worry, fear, or experiencing anxiety, depression, insomnia, etc. The therapist may challenge assumptions or perceptions or propose different ways of looking at, thinking about or handling situations that could cause clients to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues in relationships may result in changes that were not originally intended.

Therapy may result in the need for decisions about changing behaviors, employment, substance use, schooling, housing, or relationships, although those decisions are always the clients' to make. Change will sometimes be easy and swift, but sometimes it will be slow and even frustrating. There is no guarantee that couples/family therapy will yield positive or intended results. The changes that any partner/spouse/family member makes may have an impact on any of the family members.

INFORMED CONSENT FOR COUPLES/FAMILY THERAPY

- I understand that couples/family therapy begins with an evaluation of our family/relationship history and current concerns.
- I understand the policies described in the Information For Clients and Informed Consent for Family Therapy and accept them as conditions for beginning therapy with the therapist.
- I understand the Limits of Confidentiality.
- I have been given the chance to ask questions and discuss confidentiality and disclosure policies with the therapist.
- I also understand that the information discussed in therapy is for the purpose of therapy only and is not intended to be used in legal proceeding between me and others, including my partner/spouse/family members.
- I agree that the role of the couple/family therapist, is to be limited to that which will therapeutically benefit the relationship, and that I will not attempt to gain an advantage in any legal proceeding from my therapy.

- **I agree not to ask the therapist to testify in court, whether by person, or by affidavit. I also agree to instruct my attorneys not to subpoena the therapist. I understand that this agreement may not prevent a judge from requiring the therapist's testimony, even though he/she will work to prevent such an event.**
- I agree to share responsibility with the therapist for the therapy process, including goal setting and termination.
- I understand that entering into couple/family therapy, working toward change and engaging in the process of therapy has some risks. I accept that these changes can have both positive and negative effects and agree to clarify and evaluate the potential consequences of these changes before continuing with them.

INFORMED CONSENT FOR EVALUATION AND TREATMENT

I acknowledge that I have read and received the INFORMATION FOR CLIENTS and the policy of INFORMED CONSENT FOR COUPLES/FAMILY THERAPY, and that I enter into therapy in agreement with this policy

Printed Name of Client _____Date _____

Signature of Client_____

Printed Name of Client _____Date _____

Signature of Client_____

Printed Name of Client _____Date _____

Signature of Client_____

Printed Name of Client _____Date _____

Signature of Client_____

Printed Name of Client _____Date _____

Signature of Client_____

PAYMENT AGREEMENT

I agree to pay for each session at the time of session. I will provide notification to the Counseling office prior to 24 hours before the scheduled appointment time if I need to cancel my appointment.
I understand that a **no-show, or a cancellation later than 24 hours prior to the scheduled appointment will result in my being charged the session fee.**

Signed _____ Date _____

Signed _____ Date _____

Consent for Therapy for Minor Children

I authorize my minor children:

_____ _____

_____ _____

_____ _____

To be seen in family therapy at Mount Olivet Counseling Service.

Name of parent/guardian: _____

Signature_____ Date_____
Parent/Guardian signature if minor client/s

Contact information: email: _____ phone _____

Name of parent/guardian: _____

Signature_____ Date_____
Parent/Guardian signature if minor client/s

Contact information: email: _____ phone _____