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**129 N. Central Avenue Laurel, DE 19956 302-280-6569**

**Confidential Minor Client Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: □ M □ F Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Biological \_\_\_ Step \_\_\_\_ Adopted \_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Biological \_\_\_\_ Step \_\_\_\_ Adopted \_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child resides with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family’s religious orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***TRAUMA HISTORY***

Has child experienced trauma □ No □ Yes

Nature of Trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Experienced physical/verbal/sexual abuse (circle all that apply)

□ Witnessed physical/verbal/sexual abuse (circle all that apply)

□ Major stress-inducing or life-threatening event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons Involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***RELATIONAL HISTORY***

Please list brothers and sisters including step, adopted and foster children:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Sex | Age/Year of death | Relationship to you | Living with whom? |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please describe your family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***COUNSELING HISTORY***

If you (minor) or your child has had previous counseling, please list the name of the therapist /counselor and/or programs:

|  |  |  |
| --- | --- | --- |
| Name of Therapist/Program | Issues Addressed | Dates in Treatment |
|  |  |  |
|  |  |  |
|  |  |  |

**Medical History**

List any physical illness or conditions over the last year that might be relevant to you seeking counseling for you (minor) or your child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Please list all current medications you are taking (even if use is seldom or as needed):

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dosage | Reason for taking medicine |
|  |  |  |
|  |  |  |
|  |  |  |

**Present Issues and Goals**

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

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

Check any of the following symptoms or problems that you are currently or have recently experienced:

□ Impulsive behavior □ Sexual problems □ Verbal abuse □ Fears

□ Grief/Loss □ Sexual abuse □ Sexual addiction □ Physical Abuse

□ Obsessive thoughts □ Depression □ Loneliness □ Stress

□ Emotional Abuse □ Chronic pain □ Panic Attacks □ Anxiety

□ Indecisiveness □ Withdrawal □ Gender identity □ Anger

□ Hearing voices □ Hallucinations □ Fatigue □ Poor concentration

□ Low self-esteem □ Loss of appetite □ Bad dreams □ Aggression

□ Racing thoughts □ Trouble sleeping □ Apathy □ Spiritual Apathy/concerns

□ Alcohol use □ Drug use □ Eating problems □ Career choices

□ Relational issues □ Work issues □ Loss of control □ Controlled by others

□ Feeling worthless □ Pornography □ Unwanted memories

□ Pregnancy/Abortion □ Uncertainty of salvation □ Compulsive behavior

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please place an “X” on the scale to indicate how distressing your problems are to you.

(-----------------------------------------------------------------------------------------------------------------------------------)

Very minimal distress Moderate distress Very extreme distress

Are you currently experiencing any suicidal thoughts? □ Yes □ No

Have you experienced suicidal thoughts or attempted suicide in the past? □ Yes □ No

Are you currently experiencing any violent or homicidal thoughts? □ Yes □ No

How long has the current situation been present?

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

**Client’s Signature (Parent or Guardian if a Minor) Date**

**Informed Consent for Counseling Services**

This document describes how counseling services will be provided through A Father’s Heart (AFH). Please review carefully. Your signature(s) indicates your agreement to received care or authorize care for a minor under the following conditions.

1) We are dedicated to maintaining the privacy of your personal information and is an integral part of providing quality care. Counselor may use Therapy Notes™, an extremely secure electronic health record system, for record keeping, notes and scheduling. All that is discussed as well as your counseling records are kept confidential, except where disclosure is required by law:

1. When you indicate intent to seriously harm yourself or others.
2. When you indicate involvement in, or disclose knowledge of incidents of abuse to children, the elderly, or the mentally handicapped.
3. When the Pastoral Counselor is directed by legal authority, such as a judge’s order as part of a court proceeding.
4. When you have signed the appropriate release of information forms.

2) Counseling will cover emotional, physical, and spiritual aspects of your life and may sometimes be distressing and difficult. However, you understand working through your present situation will enable you to achieve increased wellness spiritually, personally, and relationally.

3) You have the right to ask questions pertaining to your treatment, help set goals and follow through with agreed upon goals and may discontinue counseling at any time. You understand terminating counseling is best decided after consulting with your Counselor.

4) Counselor’s credentialing – Sharon Brown, Pastoral Counselor is approved yet not licensed by the State of Delaware. She has received a Master of Arts in Pastoral Counseling: Marriage and Families through Liberty University and has met criteria required to providing pastoral or Biblical counseling services for those issues and problems within the sphere of training and competency. She is also trained in EMDR, a research-based integrative psychotherapy that helps with healing trauma (past or recent), PTSD symptoms, and persistent negative beliefs about oneself and much more.

Rob Brown, ordained Pastor through Elim Fellowship of Lima, New York, has pastored and counseled for more than seventeen years of which nine of those included counseling and discipling men enrolled in Teen Challenge who were recovering from a variety of addictions.

The Pastoral Counselors’ goal is to help clients explore their central values in life, including religious and spiritual values, to help resolve the issues brought in for counseling. Their Christian beliefs are the foundations from which they operate coupled with the education, training and credentialing received to perform as Pastoral Counselors. Their personal and counseling values are guided by the Bible and Christian faith and are open to helping people who share that faith as well as others who have different faith values. However, serious differences in basic life values or counseling goals may hinder the effectiveness of the counseling process.

5) Sessions typically run 60-minute sessions unless additional time is agreed upon by all parties. Because the Pastoral Counselor is not licensed by the state of Delaware, insurance is not accepted. **The cost for each individual session is** **$60; pre-marital and marriage is $95 which is payable at time of session** in the form of cash, check or credit card. If you choose to pay by personal check and it is returned from the bank as “insufficient funds”, a charge of $35.00 per return will be added to your account. If this should occur, personal checks will no longer be accepted, and any outstanding balance will need to be paid prior to next counseling session. **Payment is due at time of appointment.**

HSA account payments are accepted only through Therapy Notes, the electronic health records system, utilized by AFH. Please check with employer’s HR department to ensure Pastoral Counseling qualifies as some agencies require a licensed Mental Health Therapist.

6) **Cancellations:** Since the scheduling of an appointment involves the reservation of time set aside especially for you, a minimum of 24 hours’ notice is required for rescheduling or cancellation of an appointment. This allows us time to schedule another client who may be on the wait list. We understand emergencies and illnesses happen and thank you for being mindful of our policy. However, **if less than 24 hours is given to cancel a session repeatedly, a cancellation fee of the full session will be charged**. You may also inquire whether there is an option to meet virtually if you’re unable to attend in-person session.

7) In the instance where no progress is being achieved, the type of counseling needed is beyond the scope of this Counselor, or Counselor is not able to continue meeting with client for appropriate reasons, every reasonable effort will be made to provide counseling to another professional who has greater competency in the required area of treatment. It is not the intention to abandon or neglect client, but to provide continuity of services. Counselor or client has the right to terminate the counseling relationship at any time.

8) It is the Counselor’s duty to maintain a professional relationship with client. Counselor will ensure all reasonable steps are taken to avoid harming clients and always look out for the best interest of the client.

9) The Counselor realizes the power that can be associated within the client relationship and will not take advantage of client by abusing trust and encouraging dependence. Dual relationships with individuals that could potentially impair judgment and compromise integrity are discouraged. In instances when dual relationships are unavoidable, particularly within congregation, with friends or business relationships, the Pastoral Counselor will ensure reasonable steps are in place to protect the clients clear and appropriate boundaries are established.

10) Any form of sexual behavior or romantic involvement is considered unethical and strictly prohibited regardless of if it is consented to or initiated by the client.

11) In-person and Telehealth services through Therapy Portal or Zoom are available to clients. If you are experiencing COVID-19 symptoms, you may switch to a Telehealth appointment or cancel. If you need to cancel, you will not be charged a late cancellation fee.

12) To use Telehealth services, an internet connection, and a device with a camera for video is needed. Explanation on how to log in and use any features on the Telehealth platforms will be provided. If Telehealth is not a good fit for you, we will recommend a different option such as Zoom. What you should know about using Telehealth:

* You may be asked to share personal information with the Telehealth platform to create an account, such as your name, date of birth, location, and contact information. These platforms are carefully vetted to ensure your information is secured to the appropriate standards.
* At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.
* Make sure that other people cannot hear your conversation or see your screen during sessions.
* Do not use video or audio to record your session without prior permission from Counselor.

13) Counselor may communicate with you outside of your sessions via text message, email, or phone. Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message or email. If you would like to opt out of certain communication methods, please advise your counselor.

*I have read and understood the preceding information and agree to the policies as stated.*

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

Client’s Signature (Parent or Guardian of Minor) Date

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

Client’s Signature Date

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

Pastoral Counselor’s Signature Date