**WELCOME TO THE OLIVE COUNSELING CENTER!**

Thank you for choosing our counseling center to help you with your counseling needs. We want to take this opportunity to explain our policies and procedures.

**APPOINTMENTS:**

We consider our appointments very important. Counseling is a commitment to work together. We hope you will also share in this commitment. Please do not miss sessions if possible. Therapy sessions are 50 minutes.

**LIMITS OF CONFIDENTIALITY:**

Information discussion in the counseling setting is held confidential and will not be shared without the written permission of the client except under the following conditions.

- The client threatens to harm self or another person.
- The client reports the abuse of a child, a person who is elderly, or a person who is disabled.
- The client reports sexual exploitation by a counselor, therapist or other mental health professional.
- Your counseling records by a state or federal court of law if legal action is taken against you.

**RECORD MAINTENANCE AND EMERGENCY SITUATIONS:**

Psychotherapy records must be maintained in our possession according to state laws. Copies of your records or a summary of such records will be provided upon written request. Reasonable cost of reproduction and time to prepare such records will be charged. If you should experience an emotional or behavioral crisis and we cannot be reached immediately by telephone, you and your family members are instructed to contact the "HELP" Line at 438-1617, dial 911, or present yourself at the nearest hospital emergency room. Our contact number is 850-473-4461.

**FINANCIAL RESPONSIBILITY:**

You are responsible for full payment of all services regardless of insurance coverage. At the completion of each session, you will receive a receipt of service that is appropriate to file with your insurance for reimbursement. Please make checks payable to Olive Baptist Church. Fees are as follows:

| | |
|---|---|
| Individual Initial Intake Session: | $110.00 (50 minutes) |
| Individual Session: | $100.00 (50 minutes) |
| Family/Couple Initial Session: | $135.00 (50 minutes) |
| Family/Couple Session: | $135.00 (50 minutes) |

(We offer a sliding fee scale based on household income. Please let us know if you need this service. We do not want money to be the reason you do not receive help.)

We accept the following major credit cards: Visa, MasterCard, Discover and American Express. No fees will be charged for appointments canceled 24 hours or more prior to appointment date and time. *If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a charge of half your session fee.* You will not be seen again until the cancellation charge is paid. To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment. Voice mail is available 24 hours a day and messages are checked each business day. You may call 850-473-4461.

**SOCIAL MEDIA AND TELECOMMUNICATION**

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc.) We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about this matter.

I have read the Financial and Confidential Policies outlined in this document and agree to comply with these policies. I agree to the limits of confidentiality.

______________________________________________________________________

Client's Signature Date

______________________________________________________________________

Parent or Guardian's Signature Date

______________________________________________________________________

Counselor's Signature Date

______I have your permission to leave a message at the contact number if I need to reach you or as a courtesy call for an appointment reminder. I cannot ensure confidentiality through a text message.

*Olive Counseling Center*
1830 E Olive Road
Pensacola, Florida 32514
850-473-4461

## FACE SHEET

1. Patient Name: ______________________________________________
(Last) (First) (MI) (Nickname)

2. Address:______________________________________________
Street City State Zip Code

3. Email: ______________________________________________

4. Home Phone: ( )______________________ Cell: ( )______________________

5. Work Phone: ( )________________ 6. DOB: ______________ Age: __________

7. Sex: M F 8. Marital Status: Single Married Divorced Widowed

9. Employer: ______________________ 10. Occupation: ______________________

11. Student/School: ______________________________

12. If dependent child, are custodial parents: ____ Married ____ Separated _____ Divorced ____ Other __

13. Religion: ______________________ 14. REFERRED BY: ______________________

15. IN CASE OF EMERGENCY NOTIFY:

Name:______________________ Relationship: ____________ Phone( )____________

******************************************************************************

## FINANCIALLY RESPONSIBLE PARTY

Guarantor's Name: ______________________________________Birth Date: ____________

Guarantor's Address:______________________________________________

Guarantor's Relationship to Patient ______________________________________

Guarantor's Employer: ______________________ Phone:( ) ______________________
___--__
******************************************************************************

I understand I am financially responsible for all service rendered to me or the client and agree to pay charges at the time services are provided.

Client Signature______________________________ Date:______________________

## Parental Consent to Treat a Minor

I, ___________________________________________________________________

(name of Parent or Guardian of child),

give my permission for my child,

_______________________________________________

(full name of Minor),

_______________________________________________

(birth date AND age of Minor),

to be treated by ________________________________________ in psychotherapy.

I also understand that for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, **with exceptions of if the minor is a danger to himself/herself or to others.**

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _______________________________________ (date consent expires).

_____________________________________________________________________

Parent or Guardian's Signature     Relationship to Minor     Today's Date

_____________________________________________________________________

Print name of Parent or Guardian

_____________________________________________________________________

Address of Parent or Guardian     (Street, City, State, Zip code)

_____________________________________________________________________

Other Parent or Guardian's Signature     Relationship to Minor     Today's Date

_____________________________________________________________________

Print name of Other Parent or Guardian

_____________________________________________________________________

Address of Parent or Guardian     (Street, City, State, Zip code)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative.) My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent and willing consent.

_____________________________________________________________________
Therapist                                                                                    Date

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

## ADOLESCENT INTAKE FORM (ages 12-17)

**(To be completed by the adolescent)**

**CLIENT INFORMATION**

Name:______________________________________________________________

Date of Birth: ______________________________ Age: ____________ ❒ Male ❒ Female

Physical Address: ______________________________________________________________

Mailing Address: ______________________________________________________________

Phone (Cell): __________________________ Messages okay? ____________

Phone (Home): ________________________ Messages okay? ____________

School: _____________________________________________________Grade: ____________

Race/Ethnic Origin: ______________________________________________________________

Religious Preference: ___________________________________________________________

**PERSONAL STRENGTHS**

What activities do you enjoy and feel you are successful when you try?

______________________________________________________________________________

______________________________________________________________________________

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

______________________________________________________________________________

______________________________________________________________________________

**CURRENT REASON FOR SEEKING COUNSELING**

Briefly describe the problem for which you are seeking counseling.

______________________________________________________________________________

______________________________________________________________________________

What would you like to see happen as a result of counseling?

______________________________________________________________________________

**COUNSELING/MEDICAL HISTORY**

Have you previously seen a counselor? ❒Yes ❒No
If yes, what did you find most helpful in therapy?

______________________________________________________________________________
______________________________________________________________________________

If yes, what did you find least helpful in therapy?

______________________________________________________________________________
______________________________________________________________________________

**CHEMICAL USE AND HISTORY**

Do you currently use alcohol? _____Yes _____No
If yes, how often do you drink? _____Daily ______Weekly _____Occasionally _____Rarely
If yes, how much do you drink? ____________ (#) per time.
Do you currently use tobacco? ______Yes _____No
If yes, how much do you smoke/chew? __________________
Do you currently use any other drugs? _______Yes ______No
If yes, what drugs do you use? _________________________________________________
If yes, how often do you use? _____Daily ______Weekly ______Occasionally _____Rarely
Have you received any previous treatment for chemical use? Y/N _________
If so, where did you go? _______________________________________________________
____Inpatient ____Outpatient

**ADOLESCENTS** (please answer the following with Y/N)

Have you ever used more than 1 chemical at the same time to get high? _______
Do you avoid family activities so you can use? _______
Do you have a group of friends who also use? _______
Do you use to improve your emotions such as when you feel sad or depressed? ____

**LEGAL ISSUES**

Please list any legal issues that are affecting you or your family at present or have had a significant effect upon you in the past. ___________________________________________

**FAMILY HISTORY**

Are your parents married or divorced? __________________
Do you think their relationship is good? Y/N /Unsure)_______________
If your parents are divorced, whom do you primarily live with? _________
How often do you see each parent? Mom_________% Dad ______%.
Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

______________________________________________________________________________

**FAMILY CONCERNS** (Please check any family concerns that your family is currently experiencing.)

____Fighting
____Feeling distant
____Loss of fun
____Lack of honesty
____Medical Concerns
____Education problems
____Financial problems
____Death of a family member
____Inadequate health insurance
____Inadequate housing/feeling unsafe Other
____Disagreeing about relatives
____Disagreeing about friends
____Alcohol or Drug use
____Trauma
____Infidelity (couple)
____Divorce/separation
____Issues regarding remarriage
____Birth of a child
____Job change or job dissatisfaction

Other concerns not listed:
______________________________________________________________________________

**PEER RELATIONS**

How do you consider yourself socially: __outgoing ___shy ___depends on the situation
Are you happy with the number of friends you have? (Y/N) ________________
Have you ever been bullied? (Y/N) ____________
Are your parents happy with your friends? (Y/N) _____________________
Are involved in any organized social activities (e.g. sports, scouts, music)?
______________________________________________________________________________

**SCHOOL HISTORY**

Do you like school? (Y/N) __________________
Do you attend regularly? (Y/N) _____________
What are your current grades? ______________________
Do you feel you are doing the best you can at school? (Y/N) ___________________
Is there anything else you would like me to know:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

*Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.*

## ADOLESCENT INTAKE FORM (ages 12-17)
### (To Be Filled Out by the Parent(s)

**Adolescent's Name:** ________________________________________DOB: _____________
Mother's/Guardian's Name: _____________________________________________________
Phone Contact: Home: (    )_______________________ Cell: (    )______________________
Mother's/Guardian's Physical Address:
_____________________________________________________________________________
Mother's/Guardian's Mailing Address:
_____________________________________________________________________________

Father's/Guardian's Name: ______________________________________________________
Phone Contact: Home: (    ) ________________________ Cell: (    )____________________
Father's/Guardian's Physical Address:
_____________________________________________________________________________
Father's/Guardian's Mailing Address:
_____________________________________________________________________________

**CURRENT HOUSEHOLD AND FAMILY INFORMATION**
Name: __________________________Age:____Sex:____Living with you? Y/N____________
Relationship (parent, sibling, etc): ____________ Type (bio, step, etc): _________________

Name: __________________________Age:____Sex:____Living with you? Y/N____________
Relationship (parent, sibling, etc): ____________ Type (bio, step, etc): _________________

Name: __________________________Age:____Sex:____Living with you? Y/N____________
Relationship (parent, sibling, etc): ____________ Type (bio, step, etc): _________________

Name: __________________________Age:____Sex:____Living with you? Y/N____________
Relationship (parent, sibling, etc): ____________ Type (bio, step, etc): _________________

Name: __________________________Age:____Sex:____Living with you? Y/N____________
Relationship (parent, sibling, etc): ____________ Type (bio, step, etc): _________________

Name: ____________________________Age:____Sex:____Living with you? Y/N_____________
Relationship (parent, sibling, etc): _____________ Type (bio, step, etc): ___________________
Name: ____________________________Age:____Sex:____Living with you? Y/N_____________
Relationship (parent, sibling, etc): _____________ Type (bio, step, etc): ___________________

Name: ____________________________Age:____Sex:____Living with you? Y/N_____________
Relationship (parent, sibling, etc): _____________ Type (bio, step, etc): ___________________

(If additional space is need please list on the back of page)

**Current Reason for Seeking Counseling for Your Adolescent:**
Briefly describe the problem for which your adolescent is seeking counseling?
_______________________________________________________________________________
_______________________________________________________________________________
What would you like to see happen as a result of counseling?
_______________________________________________________________________________
_______________________________________________________________________________
What is most concerning right now?
_______________________________________________________________________________
_______________________________________________________________________________

**COUNSELING HISTORY**
Have your son or daughter previously seen a counselor? ❒Yes ❒No If Yes, where:
_______________________________________________________________________________

Approximate Dates of Counseling:
_______________________________________________________________________________
For what reason did your son or daughter go to counseling?
_______________________________________________________________________________
_______________________________________________________________________________
Does your son or daughter have a previous mental health diagnosis?
_______________________________________________________________________________
What did you find most helpful in therapy?
_______________________________________________________________________________
_______________________________________________________________________________
What did you find least helpful in therapy?
_______________________________________________________________________________
_______________________________________________________________________________

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?
________________________________________________________________________________
If yes, was it helpful? N/A____ Yes____ No______

Has your son or daughter taken medication for a mental health concern? Yes ____ No _____
Does your son or daughter have other medical concerns or previous hospitalizations? Y/N ___
If so, please describe: ____________________________________________________________
________________________________________________________________________________

**CHILD'S DEVELOPMENT**
Were there any complications with the pregnancy or delivery of your child?
Yes ___ No ___ If yes, describe:
________________________________________________________________________________
________________________________________________________________________________
Did your child have health problems at birth? Yes _____ No ______ If yes, describe:
________________________________________________________________________________
______________________________________________________________________________
Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
Yes ___ No ___ Not sure_____ If yes, describe:
________________________________________________________________________________
________________________________________________________________________________
Did your child have any unusual behaviors or problems prior to age 3?
Yes ___ No ___ Not sure_____ If yes, describe:
________________________________________________________________________________
________________________________________________________________________________
Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Not sure _____ If yes, describe:
________________________________________________________________________________
________________________________________________________________________________

**CHEMICAL USE**
Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _________
If yes, please explain your concern:
________________________________________________________________________________
________________________________________________________________________________

**INTERNET/ELECTRONIC COMMUNICATIONS USAGE**
Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _________

If yes, please explain your concern:

______________________________________________________________________________

______________________________________________________________________________

**LEGAL ISSUES**

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

______________________________________________________________________________

____________________________________________________________________________

**FAMILY HISTORY**

*(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)*

Father's Name: ____________________________________DOB:_____________ Age: ______
Ethnic Origin: ___________________________________________________________________
Total years of education completed: ____________ Occupation: ________________________
Place of Employment: ____________________________________________________________
Military experience? Y/N _______________ Combat experience? Y/N _____________________
Assessment of current relationship if applicable: Poor_____ Fair_______ Good_________

Mother's Name: _____________________________________DOB:_____________ Age: _____
Ethnic Origin: ___________________________________________________________________
Total years of education completed: ____________ Occupation: ________________________
Place of Employment: ____________________________________________________________
Military experience? Y/N ________________ Combat experience? Y/N ____________________
Assessment of current relationship if applicable: Poor_____ Fair_______ Good_________

**PARENT'S MARITAL STATUS**

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated
❒Widowed ❒Other _______________________________________________________________
Length of marriage/relationship:____________________________________
If divorced, how old was your child at time of divorce? __________________
If divorced, how much time does your child spend with each parent?
Mother____________%, Father ___________%

**FAMILY CONCERNS** Please check any family concerns that your family is currently experiencing:

___Alcohol or drug use
___Birth of a child
___Death of a family member
___Disagreeing about friends
___Disagreeing about relatives
___Divorce
___Education problems
___Feeling distant
___Fighting
___Financial problems
___Inadequate health insurance
___Inadequate housing/feeling safe
___Infidelity (couple)
___Issues regarding remarriage
___Job change or dissatisfaction
___Lack of honesty
___Loss of fun
___Medical concerns
___Trauma
___Other (Describe:)____________________________
____________________________________________

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

________________________________________________________________________
________________________________________________________________________

**YOUR ADOLESCENT'S STRENGTHS**

What activities do you feel your son or daughter is successful when they try?

________________________________________________________________________
________________________________________________________________________

What personal qualities would you say your son or daughter has?

________________________________________________________________________
________________________________________________________________________

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Is there anything else you would like me to know?

________________________________________________________________________