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:

- Initial Intake Session: $100.00 (50 minutes)
- Individual Session: $90.00 (50 minutes)
- Family/Couple Initial Session: $120.00 (50 minutes)
- Family/Couple Session: $120.00 (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. Voice mail is available 24 hours a day and messages are checked daily. 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.
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: __________


11. Student/School: ____________________________

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


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:___________________________
Consent to Treatment

I do hereby seek and consent to take part in treatment with _____________________.

I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I acknowledge that I have been informed counseling can be a painful process. I have had all my questions answered fully.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)

I know I must call to cancel an appointment at least 24 hours before the time of the appointment to avoid late cancellation charges. I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), cost(s) and providers of any service or treatments I receive. I understand payment for service is due at the end of each session, and I am responsible for full payment regardless of insurance coverage.

My signature below shows I understand and agree with all these statements.

_______________________________________________________________________
Signature of client (parent, guardian, or other representative)  Date

_______________________________________________________________________
Relationship to Client

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

1830 E OLIVE ROAD | PENSACOLA | FLORDIA | 32514 | OFFICE: 850.473.4461 Page | 5
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 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)*

<table>
<thead>
<tr>
<th>Adolescent’s Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s/Guardian’s Name:</td>
<td></td>
</tr>
<tr>
<td>Phone Contact: Home: ( )</td>
<td>Cell: ( )</td>
</tr>
<tr>
<td>Mother’s/Guardian’s Physical Address:</td>
<td></td>
</tr>
<tr>
<td>Mother’s/Guardian’s Mailing Address:</td>
<td></td>
</tr>
</tbody>
</table>

| 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**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
<th>Sex:</th>
<th>Living with you? Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship (parent, sibling, etc):</td>
<td>Type (bio, step, etc):</td>
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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 ☐ Cohabiting ☐ 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?