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(970) 985-2736 • www.CCCGJ.com • info@cccgj.com

ADULT INTAKE FORM

Date: ___________________________

Client Name:____________________________________ Spouse's Name: ________________________________
(if married)
Address____ City_________________ Zip______________

Cell/Home Phone: _______________ Work Phone: ______________ Email: ____________________________

Age: ______ D.O.B. _______ SS# ____________ Marital Status: Married|Single|Divorced|Remarried|Widow(er)

Occupation: ____________________________ Employer: ____

Religious Affiliation ___________________ Name of Church Currently Attending__________________________

Marital History: Never married ______________
1st Marriage: Date(s) ______________ Spouse____________ Children and Ages__________________________
2nd Marriage: Date(s) _____________ Spouse____________ Children and Ages__________________________
3rd Marriage: Date(s) ______________ Spouse____________ Children and Ages__________________________

Who has custody of your minor children: ____

Briefly describe your reasons for seeking help:

____

____

____

____

Would you like to use your health insurance to be reimbursed for session fees? Yes | No

How were you referred to this office? Circle the best answer:

Online CCCGJ.com Online directory Theravive.com Psychology Today

Other: ____

Phone Book: Mesa County Phone Book Yellow Pages Phone Book

TV or **Newspaper**

Other:____

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Statement of Confidentiality
The Client-Therapist relationship offers confidentiality in so far as allowed by the laws of the State of Colorado. Under certain conditions, the right to confidentiality is necessarily violated. There are four major exceptions to confidentiality that Colorado law requires all mental health professionals to report:

1. Incidences of child or elder abuse or neglect.
2. Intent to commit suicide
3. Threats to do harm to yourself or another person.
4. Court order

Thank you for completing this form.

PLEASE SIGN AND RETURN TO THERAPIST
By signing this document, I certify that I am the client or am duly authorized to furnish this information. I understand that I am responsible for all charges whether paid by insurance or not. I also authorize the release of any information by the therapist necessary to secure payment of fees.

Signature: ____ Date: __________________________

Signature of Spouse: _______________________________________ Date: __________________________

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Have you had previous psychological counseling or psychiatric help? Please check all that apply.

Method	When	Where	What were the issues?
Individual			
Group			
Marriage			
Hospitalization(s)			

List any health problems for which you are currently receiving treatment: ________________________________

____

Medication(s): ____

____

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FAMILY HISTORY

History in the Family:

Mental Illness in family____

Substance Abuse in family____

Domestic Violence in family____

Sexual Abuse in family____

Physical Abuse in family____

Neglect in family____

Suicidal Attempt(s) in family____

Suicide in family____

Custody Issues____

History of Self:

Self-Harm to Self (list methods)____

Suicidal Attempt Self____

Neglected as a Child____

School Currently Enrolled____

School History of being Expelled____

School Behavior____

Surgeries____

Accidents____

Age 0 – 5: Separation from mother____

Age 0 – 5 Hospital stays____

Strengths____

Interests/Hobbies____

Supports____

Family Member Closest to____

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Circle Any of the following which are currently causing you difficulty:

Anger	Health	Career choices	Parenting
My Past	Dating	Hopelessness	Food
Anxiety	Sexual Problems	Marriage	Religion
Nightmares	Panic Attacks	Concentration	Finances
Phobia	Grief	Work	Headaches
Assertiveness	Suicidal thoughts	Energy	Abuse
Addiction	Parents	Sleep Trouble	Violence
Divorce	Hearing Voices	Guilt	Sadness
Self-Control	Depression	Step-family	In-laws
Cutting	Obsessiveness	Legal Issues	

OTHER AREAS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, (Please Print Full Name) ______________________________________ have received a copy of Christian Counseling Center, LLC's Notice of Privacy Practices.

____
(Signature)

____
(Date)

FOR OFFICE USE ONLY

Christian Counseling Center, LLC attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

____

____

____

____

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DISCLOSURE STATEMENT
For Chris Cline, MA

Degrees and Qualifications
Currently an unlicensed therapist with a Master of Arts in Counseling .
Colorado Christian University, Lakewood CO, Master of Arts in Counseling, 2007.
Regis University, Englewood CO, Bachelor of Science in Psychology, 2002.
Certified Splankna Practitioner since December 2013. Splankna Practitioner since November 2010.
Special Interests: individuals, adolescents, children, victims of domestic violence, trauma, and sexual abuse, family therapy and anger management.

The Colorado Department of Regulatory Agencies has the general responsibility of regulating the practice of licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, certified school psychologists, and unlicensed individuals who practice psychotherapy.

The agency within the Department that has responsibility specifically for Licensed Professional Counselors (LPC) is the LPC Board, 1560 Broadway, Suite 1350, Denver, CO 80202. Their phone number is (303) 894-7766.

Client Rights and Important Information

A. You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. Please ask if you would like to receive this information.
B. You can seek a second opinion from another therapist or terminate therapy at any time.
C. In a professional relationship (such as ours), sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board.
D. Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist, or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. There are exceptions to the general rule of confidentiality. These include: (1) Intent to harm yourself or others, (2) Abuse, suspected abuse of children or the elderly, or neglect or suspected neglect of children and (3) In the event that I am sued by you in a criminal or delinquency proceeding.

In marriage and family counseling, the therapist holds a "**no secrets**" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist that requires differential discriminatory treatment of family members.

If you have any questions or would like additional information, please feel free to ask during the initial session and any time during the psychotherapy process.

CLIENT SIGNATURE, ACKNOWLEDGEMENT AND AGREEMENT
I have read the preceding information and understand my rights as a client.

______________________________ __________ **** ________________________________ ____________

Client or Authorized Agent **Date** **Spouse if for Marital Counseling** **Date**

(Counselor Copy) Copy given to Client? ______ Therapist signature________________________________

CLIENT INFORMED SPLANKNA CONSENT

Thank you for your interest in working with me as a client. I am providing you with the following information so you can make an informed choice about your decision to engage my services. Please read this information carefully and let me know if there is any part you do not understand.

Theoretical Approach

My method of (performance work/coaching/support work) is called Splankna Therapy. It is a biblically based protocol for energy psychology. "Energy Psychology" utilizes the same system in the body that acupuncture and chiropractic are based on to resolve unbalanced emotions that are stored in the body. "Energy Techniques" is a collective term used to refer to a variety of methods based on the use, modification, and manipulation of energy fields that look at imbalances within the person's energy system as well as the energetic influence of thoughts, beliefs, and emotions on the body. The prevailing premise of the Energy Techniques is that the flow and balance of the body's electromagnetic and more subtle energies are important for optimal physical, spiritual, and emotional functioning. Splankna Therapy is designed to help get to the origin of an emotional issue with the goal of rapidly desensitizing the emotional stress connected to a past event. Splankna Therapy incorporates elements from several newly-emerging energy-based psychotherapy, coaching, and self-help techniques, specifically Neuro-Emotional Technique, Thought Field Therapy, and Eye Movement Desensitization and Reprocessing. Prayer is intertwined throughout the protocol with a deep emphasis on trusting the lead of the Holy Spirit. Basic biblical principles are also incorporated such as confession, repentance and forgiveness.

Although Energy Techniques like Splankna Therapy appear to have promising emotional, spiritual, and physical health benefits they have yet to be fully researched by the Western academic, medical, and psychological communities and, therefore may be considered experimental. The Energy Techniques are self-regulated and they are considered alternative or complementary to the healing arts that are licensed in the State of Colorado. Because Energy Techniques are relatively new healing approaches, the extent of their effectiveness, as well as their risks and benefits, are not fully known. If you ever have questions or concerns about the nature of the theories, methods, approaches and/or techniques I use, please feel free to ask me for further resources or references.

Outcome Expectations/Risk & Benefits/Treatment Plan

Please note that it is impossible to guarantee any specific results regarding your goals using any of the approaches I offer in my practice and I cannot know how you will personally respond to any of the approaches. However, we will work together to achieve the best possible results for you. Our work together requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. You will have to work both in and out of our sessions. I will ask for your feedback and views on our work and its progress, and will expect you to respond openly and honestly. As with any intervention, there are risks associated with Energy Psychology. Risks might include remembering, talking about, or experiencing unpleasant events which results in

uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, worry, etc, or experiencing anxiety, depression or insomnia, etc., or having difficulties with other people. Being confronted with your difficulties can be very challenging. Some changes may lead to what seems to be worsening circumstances or even losses (for example, performance work can not necessarily keep a marriage intact.).
In addition, if you choose to engage Splankna Therapy, emotional or physical sensations or additional unresolved memories may surface which could be perceived as negative side effects. You may experience some temporary emotional distress and physical discomfort related to prior life experiences.

If we are to work together we will need to specify methods, risks and benefits of treatments, the approximate time commitment involved, costs and other aspects of your particular situation. We will discuss a plan that seems most appropriate to help you reach your goals. However, regardless of our work together, you agree to take full responsibility for your self-care in the emotional, mental, physical, and spiritual dimensions of your life.

Other Important Information
Please be advised that while I have a Master's degree in Counseling, what I offer is not intended to be a substitute for medical diagnosis and does not replace the services of a licensed physician or licensed psychiatrist. You agree and understand it is your responsibility to consult with your physician/psychiatrist for any specific medical problems. Further, you understand I may suggest you contact your physician or psychiatrist if I believe it's advisable. In addition, you understand that any information shared during our sessions is not to be considered a recommendation that you stop seeing your physician or using prescribed medication, if any, without consulting with your physician/psychiatrist, even if after a session it appears and indicates that such medication or treatment is unnecessary.

Use of Touch
You understand the application of Splankna Therapy includes light touch on the back of the wrist. Touch can be a potential problem in a support relationship if you feel it is inappropriate. If you have any misgivings, doubts, or any negative reactions to any physical contact, it is very important that you let me know as soon as possible so that we can discuss your concerns. You understand you have a choice about these techniques that involve touch.

Education and Training
- Currently an unlicensed therapist with a Master of Arts in Counseling.
- Colorado Christian University, Lakewood CO, Master of Arts in Counseling, 2007.
- Regis University, Englewood CO, Bachelor of Science in Psychology, 2002.
- Certified Splankna Practitioner since December 2013. Splankna Practitioner since November 2010.

Acknowledgment and Consent to Receive Services
By signing this document and any attachments hereto, you agree that I have disclosed to you sufficient information to enable you to decide to undergo or forgo any of the approaches and other services I offer. You understand that your consent to the nature of our sessions is given voluntarily, without coercion, and may be

withdrawn at any time in the future. Further, you understand that Splankna Therapy is a relatively new healing approach and the extent of its risks and benefits are not fully known and you agree to assume and accept full responsibility for all risks associated with using Splankna Therapy .You represent that you're competent and able to understand the nature and consequences of our proposed sessions and agree to be personally responsible for the fees related thereto. You have read and understand the above disclosure about the services offered by me and my training and education and you have discussed with me the nature of the services to be provided, and except in the case of gross negligence or malpractice, agree to release, indemnify, hold harmless and defend Christian Counseling Center, LLC, its owners, managing partner, members, employees, representatives, and, consultants from and against any and all claims or liability, of whatsoever kind or nature, which you, or your representatives, may have for any loss, damage, or injury, including without limitation, physical, emotional, mental, financial, or personal, arising out of or in connection with your sessions.

____ __________________

Client's Signature Date

____ __________________

Chris Cline, MA, Splankna Practitioner Date

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FEE SCHEDULE

The standard fee for counseling is $85 per fifty (50) minute session for professional therapists. The standard fee for counseling with Graduate student interns is $50 per fifty (50) minute session. Payments, scheduling and business transactions are done at the time of service or in advance. Payments can be made with cash or check or credit card (VISA, MasterCard or Discover). A $15 administrative fee will be charged on all checks that are returned for non-sufficient funds.

Phone consultations are billed in 15-minute increments ($15 minimum). All calls over ten minutes will be billed accordingly. Time spent on written reports will be charged by my hourly rates. Charges for testing are additional.

Any time needed to be spent in court will be charged at $300 per hour and will include preparation and travel time.

**************Cancellations must be made 24 hours in advance or the session will be charged.****************

Clients are seen on a fee-for-service basis only. I do not contract with any insurer. I will provide you with a receipt for the counseling service at your appointment that may be used to submit for reimbursements if you choose. I do not complete any insurance paperwork. You should know that if you select to use your health insurance plan to assist in the payment or treatment then you understand that your insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent date needed for claim processing.

All payments of all charges are the sole responsibility of the client receiving therapy or their legal parent or guardian. ***Payment is due at the time of service*** *or in advance*. The therapist is not responsible for the collection of payment from third party payers. Client is expected to pay the therapist in full and then collect from third party payers. In the event that you do not pay your bill, Christian Counseling Center reserves the right to seek payment through the use of a collection agency or through other legal means. The cost of collection may be added to your bill.

I do hereby certify that I have read, understand and agree to the terms of this contract.

____ ____________________

Signature of Client or Authorized Agent Date

____ ____________________

Signature of Spouse if for Marital Counseling Date