

Bruce Quinlan Counseling, LLC Intake Form and Informed Consent

Today's Date: _____

Date of Birth _____

Gender: Male Female (Circle One)

Age: _____

Name: _____

Address: _____

How would you like me to contact you? (Please circle response so I know how you want me to communicate with you)

Home:	yes or no	Phone:
Work:	yes or no	Phone:
Cell phone:	yes or no	Phone:
Email:	yes or no	Email address:
Other:		
Emergency contact name and number:		

PRESENT ISSUES AND GOALS

Please briefly describe why you are coming to counseling and how long has this been going on.

What do you hope to gain from this counseling experience?

Please check any of the following symptoms or problems that you currently or recently have experienced:

<input type="checkbox"/> Stress	<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Compulsive Behaviors	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Other relational problems	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Panic	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Hearing Voices	<input type="checkbox"/> Depression	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Racing thoughts
<input type="checkbox"/> Apathy	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Eating problems	<input type="checkbox"/> Fatigue/Lack of energy
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Drug use	<input type="checkbox"/> Loss of Appetite/Overeating	<input type="checkbox"/> Sexual Problems
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Gender Identity Issues	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Anger	<input type="checkbox"/> Abortion	<input type="checkbox"/> Feeling worthless
<input type="checkbox"/> Aggressive behavior	<input type="checkbox"/> Legal matters	<input type="checkbox"/> Recent death	<input type="checkbox"/> Bad dreams
<input type="checkbox"/> Work stress	<input type="checkbox"/> Grief	<input type="checkbox"/> Unwanted memories	<input type="checkbox"/> Career choices
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Loss of control	<input type="checkbox"/> Indecisiveness	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Impulsive behaviors	<input type="checkbox"/> Parenting problems	<input type="checkbox"/> Fears	<input type="checkbox"/> Controlling
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Shyness	<input type="checkbox"/> Controlled by others	<input type="checkbox"/> Spiritual problems
<input type="checkbox"/> Low self esteem	<input type="checkbox"/> Obsessive thoughts	<input type="checkbox"/> Cutting/self harm	<input type="checkbox"/> Other: _____

Please circle the number that best indicates how distressing your problems are to you currently

1 2 3 4 5 6 7 8 9 10
 Minimally distressed Moderately distressed Extremely distressed

PSYCHOSOCIAL INFORMATION

Please check the level of education you have completed: HS Graduate GED Some College AA/2 yrs college
 BA/BS 4 yrs college Some Graduate School MA/2 yrs graduate Ph.D/4+ yrs graduate school Post-Graduate Studies

Occupation _____ Level of satisfaction with your occupation _____
 Do you regularly attend a church or other religious institution? Yes No If yes, which one? _____
 Describe your religious background, your relationship to God, and the degree you want Christian healing and spirituality included in your plan of care. _____

Have you ever participated in any satanic, occult, or New Age religious practices? If yes please describe. _____

RELATIONAL INFORMATION

Spouse's/partner's name: _____ Age _____ Spouse/partner previously married? _____

Married how long?	<input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> Other:
Separated how long?	Why?
Cohabiting how long?	Plan to marry: <input type="checkbox"/> Yes/When: _____ <input type="checkbox"/> No
Divorced how long?	Reason for Divorce:
Remarried how long?	
Widowed how long?	Lost spouse through:

Please list your children and who else lives in your home (including step, adopted, or foster children. Use reverse side if needed)

Name	Sex	Age or year of death	Relationship To You	Living with Whom?

FAMILY OF ORIGIN HISTORY

How well did your parents/guardians get along with each other? Great Good Fair Poor Terrible
 How well did you get along with your parents/guardians? Great Good Fair Poor Terrible
 Who in your life do you most count on? (i.e. who do you talk to or call when you have a problem)? _____
 How were you disciplined by your parents/guardians? _____
 Have you ever experienced any kind of trauma (e.g. witnessed or have been a victim of a crime, experienced a natural disaster, or been a victim of emotional, verbal, physical, or sexual abuse)? Indicate age at time of event(s). _____

Do you have any humiliating memories of things that were done to you by any family member, school bullies, or anyone else? _____

Has anyone in your family ever been treated or hospitalized for substance abuse, criminal behavior, mental health issues or psychiatric conditions? Yes No If yes, please describe _____

Have any of your family members or friends ever attempted or committed suicide? Yes No If yes, who and when? _____

COUNSELING HISTORY/PREVIOUS MENTAL HEALTH CARE

If you have had any previous counseling, psychiatric treatment, substance abuse treatment or residential/inpatient care, please list the names of the therapists or programs. Use back of sheet if necessary.

Therapist's Name or Program	Major Issue	Dates

MEDICAL HISTORY

Please list past or present conditions, illnesses, treatment, or surgeries that might be relevant to your reason for seeking counseling.

Describe any family history of any of these conditions or illnesses _____

Are you currently receiving any medical treatment? Yes No If yes, please describe _____

Date and outcome of last physical exam: _____

Primary care physician name: _____

Please list all medications and herbal remedies you are taking and the reason for taking them.

Name of Medication	Dose	Used for

ALCOHOL OR DRUG USE

Substance	Age of First Use	Currently Using?	How Often?	Amount	Last Use	How long?
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				

If currently using any substances, has your use interfered with any aspect of your life? (e.g. work, school, family, relationships)

CURRENT SYMPTOMS

Are you currently experiencing any suicidal thoughts? Yes No

Have you experienced suicidal thoughts in the past? Yes No If yes, when? _____

Have you attempted suicide in the past? Yes No If yes, please explain: _____

Are you currently experiencing any violent or homicidal thoughts? Yes No If yes, please explain: _____

Describe anything else you wish to point out or emphasize in the space below.

Please bring this completed form to your first appointment. All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible. I have answered all questions truthfully and to the best of my ability to be able to achieve the best clinical outcome.

Client Signature Date

Dr. Quinlan's Signature Date

PRACTICE INFORMATION AND INFORMED CONSENT FOR TREATMENT

ABOUT DR. BRUCE QUINLAN COUNSELING LLC AND THE CHRISTIAN COUNSELING AND HEALING CENTER (“CENTER”)

Thank you for choosing me as a provider of Christian spiritual and psychological counseling and healing prayer. It is my desire to provide emotionally validating and spiritually empowering care for you during the course of our sessions.

I have a Master of Arts degree in Professional Counseling from Liberty University’s accredited Christian professional clinical counseling program (2012). I also have a Doctor of Ministry degree from Ashland Seminary in Formational Counseling which is a blend of Christian counseling and inner healing (2015). My doctoral dissertation and forthcoming book called “The Essentials of Christian Healing” describe all of the various means of healing I and others have come to experience and promote through application of the Bible, through the common grace of personal counseling, and through the healing gifts the Holy Spirit has bestowed on some of us. I have a Master of Divinity degree from Trinity Evangelical Divinity School in Deerfield, IL and am an ordained minister. I also have two Masters degrees in business.

It is important that you know that I have chosen to not become a state-licensed counselor for reasons of my Christian faith, how I enable God’s power to happen, and because of my own ethics. You, as one of my clients, benefit from this because I bring a wealth of spiritual, mental, emotional, and relational treatments to assist you that are not tainted by what the state does or does not allow, and are not tainted by what the various professional secular organizations consider to be evidence-based standards of care. Often I use similar evidence-based treatments such as cognitive behavioral therapy for depression but I do not limit my Christian practice to humanistic treatments. My ethics come from the Bible and the conservative Christian church while state ethics come from a humanistic standpoint. The power to heal comes through God’s extreme love, grace, and supernatural healing operating through healing prayer by me for you. I generally follow the ethics code of the American Association of Christian Counselors with a few exceptions. I have continued to receive clinical supervision and personal accountability from regular meetings with one or more mature local Christian counselor for several years and will continue to do so for a reasonable time.

I was first exposed to the power of God’s inner and emotional healing through another Christian counselor in 2002. This was at a point in time in my life where I was at the pinnacle of success in my business career as a CEO of a large healthcare company, but just as unsuccessful in my personal life. God began to heal me through times of my own great brokenness. Soon after God called me to do healing and counseling ministry and I retired from my business career. Most of what I have learned academically and in my practice since 2002 then has been relevant to my own healing and spiritual empowerment and is being passed on to you and others through this ministry Center practice. About half of my clients are individuals and another half are couples. For couples counseling I use my experience and specialty training in emotionally focused therapy to restore emotional connection in marriages in emotionally powerful ways that just happen to exemplify the Bible’s teaching on marriage. I normally refer those who need family therapy and minors under the age of 18 to counselors who are more specialized. I may choose to refer you to a more specialized provider if that seems appropriate.

My approach to Christian counseling is very eclectic. It is a blend of psychological counseling and Christian healing. It includes whatever divine supernatural healing God is also willing for people to receive through me and the treatments I do. I call what I do healing counseling because it blends mental health treatment with prayer-based supernatural healing. I also do executive and managerial coaching and/or counseling for those who are trying to navigate political and career advancement politics while trying to balance them with marriage and family life. I spent over 24 years of my business life in the executive “C-Suite” and at times running my own consulting business.

CONFIDENTIALITY

All that happens within our sessions together is strictly confidential. I will not share any information about you with anyone other than my clinical supervisor without your written permission. Because I am not licensed I am able to

keep very minimal records of your private health information. Nevertheless I do abide by Federal and State privacy laws that require that I protect your information's privacy but also require that I disclose your information under very limited circumstances. These circumstances include when 1) there is immediate danger to you or someone else, 2) there is a report of abuse or neglect of a child or vulnerable adult, 3) there is a court order, 4) it is needed for medical inquest, or 5) there is a report of unethical or illegal conduct by another mental health or medical professional. If any of these situations arise I must give out enough information to try to keep people safe. In the event that your records are subpoenaed I will attempt to provide a summary instead. All of your records are solely the property of Bruce Quinlan Counseling, LLC and they will not be copied for anyone including clients under any circumstance except pursuant to a court judge's direct order.

CLIENT'S RESPONSIBILITIES

Clients are expected to show up on time for their appointment. Full payment of all fees by credit or debit card or cash is expected for all services rendered at the time of service. I do not use a billing company and you will not receive a statement of account. Non-payment is a cause for termination of relationship. Notice of cancellation of appointment is expected 24 hours in advance of the scheduled appointment. Clients will be charged \$50 for any no-show appointments after the first one. Clients are not to show up under the influence of non-prescription drugs. If there are times when I am not available to continue care for reasons of my own illness or lack of availability, at your request I will attempt to provide online video counseling or refer you to another provider using my best efforts.

SERVICES

My normal office visit lasts about 50-55 minutes. I can make myself available upon reasonable notice and my temporal availability to do house calls in the Jacksonville area as well as the usual office visits. I charge fees to compensate me for travel time and cost as well as the actual visit time involved. Estimated fees must be paid up front. I also do video conferencing upon request. Fees must be paid in advance of the session. I do not provide any kind of treatment over the phone, through text messages, or through email.

FEE SCHEDULE, INSURANCES, AND FINANCIAL NEEDS DISCOUNTS

I do not participate in any insurance billing. The client however may request, and I will provide, a superbill for the client to submit a claim for reimbursement, provided that services have already been paid for. My normal office visit fee is \$100 for the first session, and \$85 for subsequent sessions.

I have a discount program for financial needs. The maximum discount is 50% of my usual fee if the client is at or below the approximate Federal poverty guidelines. The fee schedule also considers the numbers of household members. The discount is reduced to a lower percent based on how much the minimum income threshold is surpassed. There is no discount if income is twice or more than the approximate poverty guidelines as indicated on the Center's discount schedule. Income is based on the adjusted gross income (Line 37) of the Federal 1040 tax return.

EMERGENCY CONDITIONS Call 911 in any emergency situation.

ACKNOWLEDGEMENT AND AGREEMENT

I have read this document and consent to undergo treatment under all these terms and conditions.

CLIENT'S PRINTED NAME

Signature

Date: _____

If client is a minor, the parent or guardian must sign below to consent to the minor receiving treatment.

PARENT/GUARDIAN PRINTED NAME

Relationship to the Minor

Signature

Date: _____