LIFE SPRING COUNSELING CENTER, LLC

Thank you for choosing our counseling center. The assistance you offer us in providing all the information requested is invaluable. Your responses will help us determine the most appropriate action for your current needs. It is important that you understand your responses will be held strictly confidential except under specific conditions which will be addressed in a later part of this intake packet. Life Spring Counseling Center is a professional mental health care provider serving the greater Las Vegas area. The orientation out of which all our therapists operate is distinctly Christian and consistent with principles of healthy living presented implicitly and explicitly in the Bible. Our primary services assist individual and family growth and development issues, pre-marital and marital relationships, divorce process and recovery, and mental health issues. Counseling fees are set individually by each practitioner. It is our goal that no one who needs our services will be denied for financial reasons alone.

Name_____ M or F Date _____

SS# _____ Date of Birth _____ Age _____

Street Address_____

City_____ State _____ Zip _____Email _____

Home Phone _____ Cell Phone _____

Name of Employer _____

Business Phone _____Preferred number to contact you_____

Is it okay to leave a message to contact you from your counselor? _____

Name of parent/guardian (if under 18) _____

SS# of parent/guardian (if under 18) _____

Emergency Contact: Name _____

Phone _____ Relationship _____

How were you referred to Life Spring? _____

Payment Information

Name of Policy Holder _____ SS# _____

Insurance provider _____Employer _____

Policy # _____ Group # _____ ID # _____

Date of birth of policy holder _____Position at work

_____

Limitations to Confidentiality

The therapeutic relationship is professional and confidential and protected by ethical standards of practice. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations:

1. Cases of suspected child abuse or neglect
2. Cases of elder (60+) or disabled/incompetent person abuse/neglect
3. Cases of potential harm to self or others
4. Need for immediate hospitalization -- medical/mental health issues
5. Cases of legal claims or defense required by state or federal law
6. Cases involving a court order by a judge
7. Cases under examination by a board of examiners as part of an investigation or hearing

Your signature indicates your knowledge and understanding of the limits of your confidentiality during treatment at Life Spring.

Signature _____Date _____

Informed Consent

1. Life Spring Counseling Center will seek to provide therapy as requested and if our services are not appropriate for your concerns, we may refer you to another facility or therapist.
2. Appointments, cancellations, and changes in scheduled sessions can be made by calling the center and leaving a message or by individual arrangement with your therapist. **Please give a 24 hour cancellation notice to avoid a fee for the missed appointment and to allow others to receive help in your place.** In the event of an emergency, call 911 or follow the instructions given to you by your individual therapist.
3. Sessions are 50 minutes long and the fees will be discussed by your individual therapist. **Fees are payable at the time of service.** Counseling services provided by interns are generally not covered by insurance.
4. It is our policy not to release any information regarding your association with Life Spring Counseling Center and we will not acknowledge clients in a public area unless first approached by the client.
5. Rules of confidentiality are observed except as cited in the list of limitations or with your written consent.

I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions. I also give permission for the following minor children to participate in counseling under the same conditions.

Signature _____Date _____

Name(s) of minors _____

Relationship to minor _____

Personal Information

Current marital status (parent marital status if minor):

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Name of spouse/significant other: _____Age _____

Immediate family members (in the home or significant to you):

Name	Relationship	Age

Highest level of education: _____

Learning problems/disabilities: _____

Occupation and level of satisfaction: _____

History of previous counseling with dates: _____

_____

_____

Briefly explain why you are seeking counseling today:_____

_____

_____

Describe how the problem is affecting your daily functioning including physical symptoms or complaints: _____

_____

_____

_____

Any medical conditions diagnosed by a physician: _____

_____

_____

Current medications -- include name/dosage: _____

_____

_____

History of drugs and/or alcohol use? Please list drug of choice and date of last use:
_____

_____

_____

Any behavioral addictions/compulsions? (gambling, eating, shopping, cleanliness, relationships, pornography, etc.)
_____

_____

Currently at risk of harming yourself or another? Explain. _____

_____

_____

Attempts to harm self in the past: _____

Childhood abuse, trauma, serious illnesses, divorce/abandonment: _____

_____

_____

Family mental health history: _____

_____

_____

Personal strengths: _____

_____

_____

Support system including description of faith orientation, if applicable: _____

_____

_____

Anything else: _____