CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize ______________________________ to release to____ to obtain from____

Person(s) ______________________________

Organization ______________________________

Address ______________________________

City ____________________ State ______ Zip ________ Phone ____________

the following information:

______ Progress Notes/Report
______ Treatment Plan
______ Discharge Summary

______ Psychosocial History
______ Psychiatric Evaluation
______ Contents of entire file

______ Psychological Report/Testing
______ Medications/Medical History
______ Other (specify) ______________________________

This information is for the purpose of continued treatment or (specify)______________

____.

I understand that my records are protected under the federal and state confidentiality regulations and cannot be released without my written consent.

By signing below, I hereby release the above parties from any and all liability resulting from the release of this information.

Patient or Client ______________________________ Date of Birth ________

Signature of Patient /Client ______________________________ Date ________

Parent or Guardian ______________________________ Date ________
(if patient / Client is a minor)

Witness ______________________________ Date ________

COMPASSION CHRISTIAN COUNSELING CLINIC

Due to statements and/or impressions of intent of suicide, Compassion Christian Counseling Clinic has required that I get a doctor's or psychiatrist's examination before I may return for counseling.

I have examined and evaluated ________________________________
(Patient)

for medical and/or physical causes for potential suicide.

☐ I state that I can find no apparent medical reasons for this concern.

____
(Physician's Signature)

☐ I have made a diagnosis and have prescribed the following medications:

____

____
(Physician's Signature)

Name of Medical Office: ________________________________

Doctor's Name: ________________________________

Office Number: ________________________________

Date: ________________________________

The information asked below is to allow us to understand you and your reason more quickly for requesting counsel and to enable us to help you more expediently. Please fill out all forms as completely as possible. All information is held in the strictest confidence.

Name ______________________________ Date ______________

Address ____________________ Phone (wk)____________ (Home)__________

City____________________ State ______________ Zip Code__________

Date of Birth______________ Age______ Place of Employment____________________

In case of emergency call____________________ Phone Number______________

FAMILY BACKGROUND

Do you have children?__________ How Many?________ How many are living at home?_______

List Names: ______________________________ Age__________

______________________________ Age__________

______________________________ Age__________

______________________________ Age__________

______________________________ Age__________

Did you have a good or bad relationship with your:

Father ______________Explain: ______________________________

____

Mother ______________ Explain: ______________________________

____

Have any of your parents, grandparents, or great grandparents to your knowledge ever been involved in any occult, cultic, or non-Christian religious practices?______________

Which ones?____

Are there any addictive problems in your family history (alcohol, drugs, etc.)?__________

Is there any history of mental illness?______________________________

MARITAL BACKGROUND

Marital Status: (Please check):

Single [ ] Married [ ] Divorced [ ] Separated [ ] Widow(er) [ ] Co-habitation [ ]

If previously married, please give dates and how dissolved.____________________

____

Describe your relationship with your spouse ______________________________

____

____

CAREER AND MILITARY SERVICE

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Have you ever been in the military service? Yes__________ No__________

Were you in combat? Yes______________ No______________

Your Occupation:____

Your Employer:______________________________________ How long?__________

What type of work do you do?____

PERSONAL INFORMATION

Presently I believe my spiritual condition is: (Circle One)

Poor Fair Average Good Excellent

Presently I believe my physical condition is: (Circle One)

Poor Fair Average Good Excellent

Presently I believe my emotional condition is: (Circle One)

Poor Fair Average Good Excellent

Check the items that best describe or relate to the reason you need to receive counseling:

Bereavement:	Religious doubts:	Relationship with parents:
Depression:	Marriage problems:	Relationship with children:
Hatred:	Bitterness:	Relationship with others:
Anxiety:	Sexual Concerns:	Loss of faith in God:
Nervousness:	Adultery:	Loss of faith in self:
Fear:	Impotency:	Loss of faith in others:
Self doubt:	Frigidity:	Loss of hope:
Guilt:	Homosexuality:	Loss of meaning:
Suicidal:	Anger with God:	Loss of feelings or thoughts:
Loneliness:	Loss of love:	Loss of self respect:

If a female, have you had any discontinued pregnancies?______________

Have you ever been arrested?______________________________

____

Have you ever been institutionalized for any problem? ______________

____

Have you sought help previously? (from whom, when, the outcome?)______________

____

Describe your eating habits (i.e., are you a junk food addict, do you eat regularly or sporadic, is your diet balanced, etc.?)______________________________

____

Do you have any addictions or cravings that you find it difficult to control (sweets, drugs, alcohol, food in general, etc.?)______________________________

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How much and what type of exercise do you get?______________________________

Do you have any problems sleeping? Are you having any recurring nightmares or disturbances?______________________________

Which of the following are you presently struggling with? (Please check.)

[ ] Day dreaming
[ ] Lustful thoughts
[ ] Inferiority
[ ] Inadequacy
[ ] Worry
[ ] Fantasy
[ ] Obsessive thoughts
[ ] Insecurity
[ ] Blasphemous thoughts
[ ] Compulsive thoughts
[ ] Doubts

Concerning your emotions, whether positive or negative, which of the following describes you? (Please check).

[ ] Readily express them
[ ] Express some of my emotions but not all
[ ] Readily acknowledge their presence but reserved in expressing them
[ ] Tendency to suppress my emotions
[ ] Find it safest not to express how I feel
[ ] Tendency to disregard how I feel since I cannot trust my feelings
[ ] Consciously or subconsciously deny them; it's too painful to deal with them

Is there anyone you need to forgive?______________________________

Do you need to forgive yourself?______________________________

Do you feel loved by God? __________ Others?__________ Yourself?__________

Are you a Christian? Yes __________ No__________ Not Sure__________

What church do you now attend, if any?______________________________

How long?______________

How often do you attend? Regular_____ Frequent_____ Occasional_____ Infrequent___

If you were to die tonight, do you know where you would spend eternity?______________

Suppose you did die tonight and appeared before God in heaven, and He were to ask you, "By what right should I allow you into My presence," how would you answer Him?______________

I John 5: 11-12 says, *"God has given us eternal life, and this life is in His son. He who has the Son has the life; he who does not have the Son of God does not have the life."*

- Do you have the Son of God in you (II Corn 15:3)?______________________________

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- When did you receive Him (John 1:12)?_______________

Are you plagued with doubts concerning your salvation? _______________

Are you under authority of a local church where the Bible is taught and do you regularly support it with your time, talent, and treasure? If not, why not? _______________

____

____

Do you believe you have been filled with the Holy Spirit?_______________

Are you spending significant, regular time in prayer?_______________

Do you feel driven, pushed, or compelled to do things?_______________

Do you feel tormented in your mind by harmful or evil thoughts?_______________

Are you pregnant?__________

Do you take medications?_______________

List their names and purposes: _______________

____

____

Do you use alcoholic beverages? (Check One) [ ] None [ ] Some [ ] Moderately [ ] Often [ ] Everyday

Is there a family history of alcoholism?_______________ Whom?_______________

Have you ever thought of committing suicide?_______________ When?_______________

If yes, explain: _______________

____

____

Have you ever attempted suicide?_______________ When?_______________

Have you experienced a significant personal loss in the last year?_______________

If yes, explain: _______________

____

Is there a family history of physical or emotional abuse?_______________

If yes, please explain: _______________

____

Were you ever sexually abuse or molested?__________ If yes, by whom:_______________

In your own words, complete this sentence: Sex is _______________

____

Signed: _______________ Date: _______________

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