



## CHRISTIAN COUNSELING

*"Offering Hope and Healing through Redemptive Relationship"*

12647 S.W. 62nd Avenue • Portland, OR 97219  
Phone: 503-928-4777 • Fax: 503-928-4779 • Web: graceclinic.org

### GENERAL INFORMATION

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Full Name:  Mr.  Mrs.  Ms.  Miss  Dr.  Rev. \_\_\_\_\_

Nick Names: \_\_\_\_\_ Name You Prefer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Race:  White  Black  Hispanic  Asian  Other: \_\_\_\_\_ Sex:  Male  Female

### CONTACT INFORMATION

Street Address: \_\_\_\_\_ Suite or Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ May We Send Mail Here:  Yes  No

Mailing Address or Post Office Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ May We Send Mail Here:  Yes  No

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ May We Leave a Message Here:  Yes  No

Mobile Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ May We Leave a Message Here:  Yes  No

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Extension: \_\_\_\_\_ May We Leave a Message Here:  Yes  No

Email Address: \_\_\_\_\_ May We Send Email Here:  Yes  No

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Mobile Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

### EMPLOYMENT INFORMATION

Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Occupation: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

Average Annual Salary:  \$0 to \$10,000  \$20,001 to \$40,000  \$50,001 to \$60,000  \$80,001 to \$100,000  
 \$10,001 to \$20,000  \$40,001 to \$50,000  \$60,001 to \$80,000  More than \$100,000

### EDUCATION INFORMATION

Last Year of School Completed:  9  10  11  12  GED College:  1  2  3  4  Other: \_\_\_\_\_

Are You Currently in School:  Yes  No. If Yes, What Level: \_\_\_\_\_ Degree Pursuing: \_\_\_\_\_

**RELATIONAL INFORMATION**

Current Relational Status:  Single  Dating  Engaged  Married  Separated  Divorced  Widowed

Are You Content with Your Current Status:  Yes  No. If No, Briefly Explain: \_\_\_\_\_

If Married, How Long: \_\_\_\_\_ Number of Previous Marriages for You: \_\_\_\_\_ For Your Partner: \_\_\_\_\_

If Separated or Divorced, How Long: \_\_\_\_\_ If Widowed, How long: \_\_\_\_\_

Partner's Name:  Mr.  Mrs.  Ms.  Miss  Dr.  Rev. \_\_\_\_\_

How Long Have You Known Your Partner: \_\_\_\_\_ Age: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Partner's Race:  White  Black  Hispanic  Asian  Other: \_\_\_\_\_ Partner's Sex:  Male  Female

Partner's Occupation: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

Last Year of School Partner Completed:  9  10  11  12  GED College:  1  2  3  4  Other: \_\_\_\_\_

What Words Would You Use to Describe Your Partner: \_\_\_\_\_

Is Your Partner Supportive of You Seeking Counseling:  Yes  No  Unsure  Partner Doesn't Know

With Whom Do You Currently Live (Check All that Apply):  Alone  Spouse  Children  Parent(s)  Sibling(s)  
 Boyfriend  Girlfriend  Roommate  Other: \_\_\_\_\_

**CHILDREN**

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Natural, Adopted, Step)</i>	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption:  Yes  No. If Yes, When: \_\_\_\_\_

Have You Ever Had a Miscarriage or Medical Abortion:  Yes  No. If Yes, When: \_\_\_\_\_

**FAMILY OF ORIGIN**

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You <i>(e.g. Mom, Dad, Sibling, Step)</i>	Occupation	Describe Him/Her

**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Specialty (e.g. Family Practice, OB/GYN, Internal Medicine): \_\_\_\_\_

Are You Currently Receiving Medical Treatment:  Yes  No. If Yes, Please Specify: \_\_\_\_\_

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had (Use Back If Necessary):  
\_\_\_\_\_

**MEDICATIONS**

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back If Necessary):

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  Improves  Prevents  Controls: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  Improves  Prevents  Controls: \_\_\_\_\_

Are You Taking these Medication(s) According to Your Doctor's Recommendations:  Yes  No

If No, Briefly Explain: \_\_\_\_\_

**PHYSIOLOGICAL SYMPTOMS**

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

- Headaches .....  Past  Present    Dizziness .....  Past  Present    Stomach Trouble ....  Past  Present
- Visual Trouble .....  Past  Present    Sleep Trouble .....  Past  Present    Trouble Relaxing ....  Past  Present
- Weakness .....  Past  Present    Tension .....  Past  Present    Rapid Heart Rate ...  Past  Present
- Difficulty Breathing ..  Past  Present    Intestinal Trouble ....  Past  Present    Hearing Noises .....  Past  Present
- Change in Appetite ..  Past  Present    Tiredness .....  Past  Present    Pain .....  Past  Present
- Hearing Voices .....  Past  Present    Seeing Things .....  Past  Present    Other .....  Past  Present

Your Height: \_\_\_\_\_ Your Weight: \_\_\_\_\_ How has Your Weight Changed in the Last 2-3 Months: \_\_\_\_\_

**CURRENT STATUS**

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

- Stress .....  You  Family    Nervousness .....  You  Family    Anxiety .....  You  Family
- Panic .....  You  Family    Unhappiness .....  You  Family    Depression .....  You  Family
- Guilt .....  You  Family    Apathy .....  You  Family    Terminal Illness .....  You  Family
- Recent Death .....  You  Family    Grief .....  You  Family    Hopelessness .....  You  Family
- Inferiority Feelings .....  You  Family    Defective Feelings .....  You  Family    Loneliness .....  You  Family
- Shyness .....  You  Family    Fears .....  You  Family    Friends .....  You  Family
- Marriage .....  You  Family    Communication .....  You  Family    Physical Abuse .....  You  Family
- Emotional Abuse .....  You  Family    Verbal Abuse .....  You  Family    Sexual Abuse .....  You  Family
- Temper .....  You  Family    Anger .....  You  Family    Aggressiveness .....  You  Family
- Bad dreams .....  You  Family    Concentration .....  You  Family    Racing Thoughts .....  You  Family
- Unwanted Thoughts ...  You  Family    Memory .....  You  Family    Loss of Control .....  You  Family
- Impulsive Behavior ....  You  Family    Self-Control .....  You  Family    Compulsivity .....  You  Family
- Sexual problems .....  You  Family    Pregnancy .....  You  Family    Abortion .....  You  Family
- Legal Matters .....  You  Family    Trauma .....  You  Family    Eating Problems .....  You  Family
- Drug Use .....  You  Family    Alcohol Use .....  You  Family    Trouble with Job .....  You  Family
- Career Choices .....  You  Family    Ambition .....  You  Family    Making Decisions .....  You  Family
- Children .....  You  Family    Being a Parent .....  You  Family    Finances .....  You  Family
- Recent Loss .....  You  Family    Disaster .....  You  Family    Other .....  You  Family

**LEVEL OF DISTRESS**

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very Little Distress; 10 = Extreme Distress):

\_\_\_\_\_

1                    2                    3                    4                    5                    6                    7                    8                    9                    10

Are You Currently Experiencing Any Suicidal Thoughts:  Yes  No. Have You Experienced Them in the Past:  Yes  No

Have you Ever Attempted Suicide:  Yes  No. If Yes,When and How: \_\_\_\_\_

Have Any of Your Friends or Family Ever Committed or Attempted Suicide:  Yes  No

If Yes,When and Who: \_\_\_\_\_

**PRESENTING ISSUES AND GOALS**

Please Describe Why You Are Coming to Counseling (i.e., What Are Your Issues, Problems?): \_\_\_\_\_

Why Have You Decided to Come for Counseling Now: \_\_\_\_\_

What Do You Hope to Gain or Change by Coming for Counseling: \_\_\_\_\_

How Long Do You Believe Counseling Should Last: \_\_\_\_\_

**PREVIOUS COUNSELING**

List any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received (Use Back If Necessary):

Therapist: \_\_\_\_\_ Location: \_\_\_\_\_ Dates: \_\_\_\_\_ Reason: \_\_\_\_\_

Therapist: \_\_\_\_\_ Location: \_\_\_\_\_ Dates: \_\_\_\_\_ Reason: \_\_\_\_\_

**RELIGIOUS BACKGROUND**

What Words Would You Use to Describe Yourself: \_\_\_\_\_

If God Were to Describe You,What Would He Say: \_\_\_\_\_

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: \_\_\_\_\_

Complete the Following Thought: God Is \_\_\_\_\_

Do You Regularly Attend a Place of Worship:  Yes  No. If Yes,Where: \_\_\_\_\_

What Is the Name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader: \_\_\_\_\_

Do You Have a Personal Support System:  Yes  No. If Yes,Who: \_\_\_\_\_

**TERMS OF SERVICE**

*I Understand that it Is Customary to Pay for Professional Services when Rendered. I Accept Full Responsibility for Payment of Any Balance Incurred for Services. I Further Understand that Without 24-Hour Notice of Intention to Cancel, I Will be Charged the Full Fee for Professional Service.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



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**INFORMED CONSENT AND RELEASE OF LIABILITY**

Grace Clinic Portland, LLC operates under contract with Meadow Springs Community Church, Inc. to provide counseling with a distinctively Christian framework to the community of believers at Meadow Springs Community Church; and at other churches, and to the local community as a whole. Counseling services are provided by Christian practitioners who have earned a Masters' Degree in Counseling from an accredited graduate program, and who have been licensed by the state of Oregon as Professional Counselors.

The Completion of an intake questionnaire, and an informed consent and release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent.

1. I \_\_\_\_\_ understand that my counselor is a Licensed Professional Counselor as specified by Oregon law.

I will allow my counselor to audio or video tape my counseling sessions on occasion for his/her supervision and continuing education. I understand that these tapes will be erased after these purposes are met. I further understand that these tapes, and all other information pertaining to these counseling sessions, will be secured in locked files and available to no one other than the staff of Grace Clinic, my counselor and his/her supervisor(s). This material will not be communicated to any other person(s) (with the exception of those named in this paragraph), in any form, without my written request and expressed written consent.

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others, HIV/Aids reporting requirements, Patriot Act reporting requirements).

I consent to the use of my records for research purposes, including the publication and dissemination of research results, understanding that this will involve no participation on my part, and that my identity and any other identifying information will be protected and kept confidential.

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby indemnify and hold harmless, release, remise and forever discharge and covenant not to sue or hold legally liable Grace Clinic Portland, LLC; Meadow Springs Community Church, Inc.; the licensed counselors; the supervisors; or the staff from any and all claims, demands, damages, actions or causes of action whatsoever related to the counseling process; the licensed counselors; the supervisors; or the staff from any and all claims, demands, damages, actions or causes of action whatsoever related to the counseling process.

I waive any right I may otherwise have to seek to use the record of my counseling with Grace Clinic as evidence in any judicial proceeding or to compel the testimony of any licensed counselor, or supervisor providing counseling to me through Grace Clinic.

*I have read and understood the preceding information and agree to the policies of Grace Clinic Portland, LLC as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through Grace Clinic.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

I, \_\_\_\_\_ have received a copy of Grace Clinic's Notice of Privacy Practices.  
*(Full Name)*

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite or Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_



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**STATEMENT OF POLICIES AND PROCEDURES**

**COUNSELING SESSIONS**

Counseling sessions with your Grace Clinic therapist are available weekly. Sessions are scheduled to begin on the hour and are 50 minutes in length. Sessions will end at 50 minutes past the hour. Therefore, it will be to your advantage to arrive on time so that you can benefit from a full-length session.

**SERVICE FEES**

Professional service fees range from \$125 to \$150 depending on your therapist's credentials and experience. *Payment is due at the time of service.* You may pay by cash or by check made payable to "Grace Clinic." Returned checks will be charged a \$20 service fee. Should you be unable to pay for all or part of a session, please speak with your counselor.

**OFFICE HOURS**

Grace Clinic's office hours are by appointment. Should you need to contact your therapist outside of your regularly scheduled appointment time please call (503) 928-4777.

**RESCHEDULING APPOINTMENTS**

It is our policy to schedule you for a "standing appointment." If you occasionally need to come at a different time, ask your counselor, who will see if an alternative appointment time is available. Please be aware that repeated cancellations or "no-shows" will result in the loss of your standing appointment.

**CANCELLATIONS**

If you must cancel your appointment, please contact your counselor *at least 24 hours in advance of your scheduled time.* You may call any time of day or night and leave a confidential voice mail message. Failure to do so will result in you being charged the full professional service fee, payable on your next visit. Your counselor has reserved a room for your session and has made himself/herself available for you at this time. Advance cancellations allow us to make the most efficient use of counselor time and office space.

**NO SHOWS**

If you fail to show up for an appointment and have not notified your counselor at least 24 hours in advance, you will be considered to have been a "no-show." *It is your responsibility to contact your counselor before your next session to confirm your next appointment* by leaving a message on his/her voice mail. After hearing from you, your counselor will then confirm your next appointment.

**CONTACTING YOUR COUNSELOR**

You may leave a confidential voice mail message for your counselor by calling (503) 928-4777, and asking for your counselor's voice mailbox. However, you may leave a message at any time by dialing (888) 861-5043 and then pressing your counselor's voice mail box number listed below.

- |                                                                |                          |
|----------------------------------------------------------------|--------------------------|
| <input type="checkbox"/> <b>Becky Young, M.A.</b> .....        | (888) 861-5043, Ext. 904 |
| LICENSED PROFESSIONAL COUNSELOR, #C2227                        |                          |
| <input type="checkbox"/> <b>Brad Young, M.A., M.Div.</b> ..... | (888) 861-5043, Ext. 902 |
| LICENSED PROFESSIONAL COUNSELOR, #C2228                        |                          |



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### NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (PROTECTED HEALTH INFORMATION) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment, and health care operations*:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information

may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your

PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.

- You may request an amendment to your PROTECTED HEALTH INFORMATION.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the *Notice of Privacy Practices*. We will make and post revisions to the *Notice of Privacy Practices* in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our *Privacy Practices*, please contact:

- The Privacy Officer  
Dawna Prostack, L.M.H.C.  
Grace Clinic Christian Counseling  
505 Park Avenue North, Suite 212  
Winter Park, FL 32789  
(407) 539-0047

For more information about HIPAA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(877) 696-6775 (TOLL FREE)