



Christian Counseling and Educational Foundation
2590 Holman Ave, Suite D
Billings, MT 59102

TEL: 406-294-5533
FAX: 406-294-5532

PERSONAL DATA INVENTORY

NAME (Please circle one) Mr. Mrs. Ms. Dr. Rev.					DATE OF BIRTH	SEX	AGE
ADDRESS (Street)		(City)		(State)		(Zip)	
HOME PHONE			CELL PHONE			BUSINESS PHONE	
OCCUPATION			EDUCATION/TRAINING			EMAIL ADDRESS	
TODAY'S DATE			REFERRED FOR COUNSELING BY				

PERSONAL HISTORY

P A R E N T S	FATHER'S NAME		AGE	OCCUPATION	MARITAL STATUS
	MOTHER'S NAME		AGE	OCCUPATION	MARITAL STATUS
	GUARDIAN'S NAME (If applicable)		RELATIONSHIP TO YOU	DATE OF GUARDIANSHIP FROM To	
	REASON FOR GUARDIANSHIP			MORE THAN ONE GUARDIANSHIP <input type="checkbox"/> YES <input type="checkbox"/> NO	
S I B L I N G S	NAME		AGE	RELATIONSHIP (Brother, Stepsister, etc.)	MARITAL STATUS
	NAME		AGE	RELATIONSHIP (Brother, Stepsister, etc.)	MARITAL STATUS
	NAME		AGE	RELATIONSHIP (Brother, Stepsister, etc.)	MARITAL STATUS
	NAME		AGE	RELATIONSHIP (Brother, Stepsister, etc.)	MARITAL STATUS
	NAME		AGE	RELATIONSHIP (Brother, Stepsister, etc.)	MARITAL STATUS
	NAME		AGE	RELATIONSHIP (Brother, Stepsister, etc.)	MARITAL STATUS
MORE THAN SIX SIBLINGS? <input type="checkbox"/> YES <input type="checkbox"/> NO					
INDICATE WHICH MIGHT HAVE APPLIED DURING CHILDHOOD AND/OR ADOLESCENCE:					
<input type="checkbox"/> EMOTIONAL/BEHAVIORAL PROBLEMS <input type="checkbox"/> SCHOOL PROBLEMS <input type="checkbox"/> FAMILY PROBLEMS <input type="checkbox"/> MEDICAL PROBLEMS <input type="checkbox"/> DRUG/ALCOHOL PROBLEMS <input type="checkbox"/> SOCIAL PROBLEMS <input type="checkbox"/> LEGAL PROBLEMS					
HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN HOSPITALIZED OR RECEIVED SOME FORM OF PROFESSIONAL HELP FOR PSYCHOLOGICAL PROBLEMS? IF SO, PLEASE SPECIFY WHO, WHEN THEY RECEIVED HELP, AND THE NATURE OF THE PROBLEM.					

OCCUPATIONAL HISTORY

WHAT POSITIONS HAVE YOU HELD IN THE PAST?

DOES YOUR PRESENT WORK SATISFY YOU? IF NOT, PLEASE EXPLAIN.

MARITAL HISTORY

MARITAL STATUS

SINGLE ENGAGED MARRIED REMARRIED SEPARATED DIVORCED WIDOWED

SPOUSE'S NAME

AGE

OCCUPATION

SPOUSE'S RELIGIOUS BACKGROUND

SPOUSE'S EDUCATION

DATE OF MARRIAGE

HAVE YOU EVER BEEN SEPARATED FROM YOUR PRESENT SPOUSE? (If yes, please specify when.)

1. FROM _____ TO _____ 2. FROM _____ TO _____

C H I L D R E N	NAME	AGE	RELATIONSHIP (Daughter, Stepson, etc.)	LIVING AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	MARITAL STATUS	OCCUPATION
	NAME	AGE	RELATIONSHIP (Daughter, Stepson, etc.)	LIVING AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	MARITAL STATUS	OCCUPATION
	NAME	AGE	RELATIONSHIP (Daughter, Stepson, etc.)	LIVING AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	MARITAL STATUS	OCCUPATION
	NAME	AGE	RELATIONSHIP (Daughter, Stepson, etc.)	LIVING AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	MARITAL STATUS	OCCUPATION
	NAME	AGE	RELATIONSHIP (Daughter, Stepson, etc.)	LIVING AT HOME <input type="checkbox"/> YES <input type="checkbox"/> NO	MARITAL STATUS	OCCUPATION

YOUR PREVIOUS MARRIAGES (If applicable)

From _____ To _____ Children from this Marriage _____

From _____ To _____ Children from this Marriage _____

YOUR SPOUSE'S PREVIOUS MARRIAGES (If applicable)

From _____ To _____ Children from this Marriage _____

From _____ To _____ Children from this Marriage _____

RELIGIOUS BACKGROUND

DENOMINATIONAL PREFERENCE

NAME OF CHURCH PRESENTLY ATTENDING

ADDRESS OF CHURCH PRESENTLY ATTENDING

CHURCH PHONE NUMBER

PASTOR'S NAME

DO WE HAVE YOUR PERMISSION TO CONSULT WITH YOUR PASTOR?

YES NO

DO YOU BELIEVE IN GOD?

YES NO UNCERTAIN

DO YOU CONSIDER YOURSELF "SAVED"?

YES NO Not sure what you mean.

IF YOU WERE TO DIE AND STAND BEFORE GOD AND HE ASKED YOU WHY HE SHOULD PERMIT YOU TO ENTER HEAVEN, HOW WOULD YOU RESPOND?

MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING PHYSICAL PROBLEMS? PLEASE CHECK ANY THAT APPLY.

<input type="checkbox"/> Heart problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Head injury/concussion <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Brain tumor <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Blackouts <input type="checkbox"/> Amnesia <input type="checkbox"/> Tremors	<input type="checkbox"/> Thyroid dysfunction <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Lung problems <input type="checkbox"/> Allergies <input type="checkbox"/> Cancer <input type="checkbox"/> Bulimia <input type="checkbox"/> Anorexia <input type="checkbox"/> Visual distortions <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Heat/cold sensitivity	<input type="checkbox"/> Bowel/bladder problems <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Recent weight change <input type="checkbox"/> Impotence <input type="checkbox"/> Physical change <input type="checkbox"/> Constant hunger <input type="checkbox"/> Food cravings <input type="checkbox"/> Fever <input type="checkbox"/> Pneumonia <input type="checkbox"/> Speech problems <input type="checkbox"/> Uncoordination <input type="checkbox"/> Menstrual irregularities	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Change in sexual drive <input type="checkbox"/> Problems walking <input type="checkbox"/> Unusual hair loss <input type="checkbox"/> Rashes <input type="checkbox"/> Memory problems <input type="checkbox"/> Episodic disorientation <input type="checkbox"/> Personality change <input type="checkbox"/> Déjà vu <input type="checkbox"/> Changes in consciousness <input type="checkbox"/> Headaches
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LIST PREVIOUS SURGERIES (Those which required anesthesia.)

LIST ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATION YOU ARE PRESENTLY TAKING. (Include diet pills, laxatives, birth control pills, cold & allergy medicines, aspirin.)

WHAT IS YOUR AVERAGE DAILY CAFFEINE CONSUMPTION? (Include coffee, tea, chocolate, stimulants, and caffeinated soft drinks.)	HOW MANY HOURS OF SLEEP DO YOU AVERAGE EACH NIGHT?	HAVE THERE BEEN ANY RECENT CHANGES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THIS SLEEP RESTFUL? <input type="checkbox"/> YES <input type="checkbox"/> NO
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HAVE YOU OR OTHERS NOTICED ANY CHANGES IN YOUR PERSONALITY (anger, mood swings, withdrawal), THINKING AND MEMORY OR WORK HABITS?

STATE IN YOUR OWN WORDS THE NATURE OF THE MAIN PROBLEM(S).

WHEN DID YOUR PROBLEMS BEGIN? PLEASE SPECIFY A DATE IF POSSIBLE.

PLEASE DESCRIBE ANY SIGNIFICANT EVENTS OCCURRING AT THAT TIME.

COUNSELING AGREEMENT

• INTRODUCTION

Welcome! We have prepared this description of our background, approach, and other information that we feel is important for you to know. Please read this carefully and feel free to ask us any questions about what you have read or anything that comes up. We know this seems rather formal and lengthy. But we believe it is very important for you to have as much information as possible so that you can make informed decisions about your counseling. Please, if you have questions or concerns, at any time, feel free directly to discuss them with your counselor. Thank you for your interest in counseling at CCEF. We look forward to the opportunity to serve you.

- Read** carefully through the following Counseling Agreement (pages 4 & 5)
- Initial** the Missed Appointments/Cancellation Policy line (page 5)
- Sign** and **date** the agreement at the bottom (page 6)
- Return** it to us before your first appointment

• DESCRIPTION OF COUNSELING

Our approach to counseling is best described as biblical counseling. You do not have to be a Christian to receive biblical counseling, but we will be using biblical principles to guide us. This approach to counseling comes from over 40 years of development and implementation at the Christian Counseling and Education Foundation in Glenside, Pennsylvania. We are partial to this approach, but there are other approaches available with other counselors. If you are interested in learning more about these, we would be happy to discuss them with you.

• FEES

The fee for a 50-minute counseling session is \$100.00 (\$150.00 for the initial session to cover set-up costs). This may be discounted if your church is willing to offset these fees through counseling grants. Payment is due at the time of each session.

It is also our practice to charge for time required in preparing assessment reports, telephone conversations lasting longer than 10 minutes, consultations, or meetings you have authorized as part of your treatment. These activities are crucial to the counseling process, and we highly value them. We will be pleased to provide you with details of any such costs when they arise.

Currently we are a provider in several insurance networks – please contact us to learn the most current information on this topic. If we are not a provider in your insurance network, you may still contact your insurance company to inquire about an individual approval or reimbursement for your session payments. Please call your insurance company to verify your benefits prior to our first session.

• CONFIDENTIALITY

Confidentiality is an important aspect of the counseling process, and we will carefully guard the information you entrust to us. To release confidential counseling information without your consent would violate both biblical standards and commonly accepted counseling ethics. There are rare situations, however, where it may be necessary for your counselor to share certain information with others (with issues of safety, as a part of counseling with you, and for your benefit). We have described those scenarios in a form called the **Provider Notice of Privacy Practices**. This form discusses the situations where we must disclose confidential information. It is important that you read and understand this form before (or by the end of) your first appointment.

• Dual relationships

“Dual relationships” in counseling refer to any situation in which counselors and counsees have another relationship or association in addition to that of counselor-counselee, such as knowing one another from church or in the community.

Not all dual relationships are avoidable or unethical. However, counseling NEVER involves sexual contact or any other dual relationship that is harmful in nature to the counselee or impairs your counselor’s judgment.

Your counselor will thoughtfully consider before entering into dual relationships. Billings is a small community in which many counsees know each other and their counselor. As a result:

- You may see someone you know in the waiting room.
- You may run into (or regularly see) your counselor and his/her family out in the community.

Please know that your counselor will NEVER acknowledge counseling you without your express (written) permission.

Many counselees choose their counselors because of knowing him/her before starting counseling and because they are aware of his/her training, background, and faith. This is good and right.

Nevertheless, your counselor will discuss with you the often-existing complexities (potential difficulties & benefits) that may be involved. Dual relationships can improve counseling but also have the capability to detract from it. Often it is impossible to know this ahead of time.

So, it is your responsibility to communicate to your counselor if a dual relationship becomes uncomfortable for you in any way. Your counselor will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if he/she finds it interfering with your counseling or your wellbeing. And, of course, please do the same as well.

I understand that a dual relationship may exist with my counselor and am open to talking about it if

necessary: _____

• **LATE CANCELLATIONS/MISSED APPOINTMENTS (PLEASE INITIAL THE FOLLOWING TO INDICATE YOUR AGREEMENT)**

_____ As a counseling ministry, I must be a careful steward of its resources, including time. If you cancel without sufficient time, that means others who could receive counseling cannot. Therefore, I require that you give me at least **2 business days** notice for cancellations.

_____ If you cancel with less than **2 business days** notice you will be charged 50% of my full hourly rate, which will be due before your next appointment.

_____ This late cancellation charge **cannot** be billed to your insurance.

_____ If you have a regular appointment slot and you cancel or miss more than once without sufficient notice, your reserved appointment slot may be given to someone else with a greater counseling need.

Signature _____ Date _____

Print Name _____

By initialing the sections above and signing this form you are agreeing to our cancellation policy in its entirety.

• **HELP BETWEEN SESSIONS**

In emergencies we cannot guarantee that you will quickly reach your counselor. **If you face a medical emergency, please dial 911.** If you have an **urgent** message, call our main number to speak directly with us, or leave a message in our voice mailbox (406-294-5533). Your counselor will contact you as soon as possible.

• **LEGALESE** (the formal and technical language of a Counseling Agreement that is often hard to understand)

This office is an affiliate office of CCEF that is independently owned and operated by CrossWord Counseling, P.C. Your counselor is a contract counselor for CrossWord Counseling, P.C. which is an independent contractor for CCEF.

• **RESOLVING CONFLICTS AND DISPUTES**

If you have any dispute with (or claim against) us, CrossWord Counseling, P.C., or CCEF, you agree to participate in a process of conciliation which involves a commitment to settling this dispute/claim by mediation and, if necessary, legally binding arbitration. Each of these steps shall be carried out in accordance with the *Rules of Procedure for Christian Conciliation* of the Institute for Christian Conciliation, a division of Peacemaker® Ministries. (A complete text of the Rules is available at <http://www.peacemaker.net>.) Judgment upon an arbitration decision may be entered in any court otherwise having jurisdiction. The parties understand that these methods shall be the sole remedy for any controversy or claim arising out of this agreement and expressly waive their right to file a lawsuit in any civil court against one another for such disputes, except to enforce an arbitration decision.

Note: Your counselor will provide counseling services under the supervision of Aaron Sironi, Licensed Clinical Professional Counselor (MT #1308).

If you have any questions or concerns about your counseling, please speak directly with your counselor. We invite and treasure your feedback. If you feel that you are unable to speak to your counselor, please contact his supervisor at (406) 294-5533.

If you do not understand any portion of this agreement, please let us know. Otherwise, please sign below indicating your acceptance of this Counseling Agreement.

SIGNED

DATE

Signature of both parents (or guardian) is also required if the counselee is a minor.

SIGNED

DATE

Signature of Father/Gardian

SIGNED

DATE

Signature of Mother/Gardian

This agreement is subject to arbitration pursuant to the Montana Arbitration Act, Title 27, Chapter 5, Montana Code Annotated.