Total Life Solutions

Informed Consent Form

Training and learning new skills is a cooperative effort between the instructor and the trainee with responsibilities resting with both the counselor and the client. In order to enable you and the trainer to work most effectively together, we ask that you carefully read the information below. If you have any questions, your counselor/coach will be happy to discuss them with you.

Total Life Solutions provides individuals with the tools to understand and improve relationships. Total Life Solutions Counseling services are available to residents of the community regardless of religious affiliation. Jon and Debra Carr are ordained ministers and have certifications in Family Wellness, Behavioral Studies Accredited DISC Training Providers, Breakthrough Parenting, Anger Management and Professional Faith-Based Biblical Counseling. We are **not** licensed, however, by the State of California. If your situation is deemed inappropriate for the type of assistance provided by this company, it will be suggested that you seek the level of professional counseling or medical assistance that is appropriate.

Confidentiality
Communications between the client and the staff of Total Life Solutions Counseling are confidential and will not be revealed unless required by law such as in situations of child abuse, elder abuse, threats of physical harm to self or others or subpoena of a court. Your counselor or coach will be discreet if it is necessary to contact you at home or work.

Insurance
We regret that Total Life Solutions does not take insurance payments. However, upon request, we will provide you with a master bill that can be submitted to your insurance company as an "out of network" provider.

Assessment
Your counselor may ask you to complete a personality inventory or some other inventory relevant to the training process. The cost usually ranges from $20 to $50 depending on the cost of processing that inventory.

Cancellation of Appointment(s)
If you must cancel your appointment, please call and leave a message at least 24 hours in advance of your scheduled appointment. If you miss a scheduled appointment, you will be billed at the full, agreed-upon session rate.

Telephone Calls
Should you need to contact your counselor, you may leave a message in our voicemail (424-571-3929) 7 days a week, 24 hours a day. Your call will be returned as soon as possible.

Emergency Procedures
The counselors or coaches are not available to handle emergencies. If you have an emergency, you will need to contact either a hospital emergency room or the police depending on the situation. Call 911.

I have read the above information and voluntarily request counseling, training and skill enhancement at Total Life Solutions and I agree with these terms and conditions. *

Signature:_____ Date:_____

* *The signature of the custodial parent or guardian is required for clients under 18 years of age.*

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Intake Form

CONTACT INFORMATION

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____ Age of Spouse: _____

Address: _____

_____

Telephone(s): Home _____ Work _____

Cell _____ Other _____

E-mail Address: _____

Contact in emergency _____ Phone _____

MARITAL STATUS

I am... Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

If married, how long? _____ Wedding Date _____

Spouse's Name _____

If separated, divorced, or widowed, when did that occur? _____

Previous marriages? _____

CHILDREN'S NAMES & BIRTHDATES | IF APPLICABLE

_____ _____

_____ _____

_____ _____

_____ _____

O C C U P A T I O N

Where do you work and what is the nature of that work? _____

_____

Do you find this work satisfying? Please explain _____

_____

E D U C A T I O N

Please circle the last year that you completed in...

Grade School | 1 2 3 4 5 6 7 8 High School | 9 10 11 12 College | 1 2 3 4 5 6 +

Other Education or Training _____

_____

F A M I L Y O F O R I G I N

	Name	Age	Education	Occupation
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Other noteworthy childhood relationships _____

_____

Significant childhood events (divorce, deaths, sickness, traumas, etc) _____

_____

_____

SPIRITUAL BACKGROUND

Do you regularly attend a church? Yes ____ No ____

Are you active in your church? Yes ____ No ____

If attending, what is the name of the church? _____

How would you characterize your current relationship with God? _____

_____

_____

CURRENT CIRCUMSTANCES

Briefly describe the problem which prompted you to seek counseling at this time _____

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped? _____

_____

_____

Were there times when the problems were especially bad? Yes_____ No_____

If yes, when? _____

What do you feel was the cause? _____

_____

_____

Are there people who play a major role in causing your problems or that help you cope?

Yes _____ No _____ Explain briefly _____

_____

Is there anything else you believe might be important for your counselor to know at this time?

_____

_____

MEDICAL CARE & HISTORY

Describe any physical problems that require medication or physical care _____

_____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult with your primary care physician? _____

Are you currently taking any prescription medications? Yes _____ No _____

If yes, please list by name and dosage _____

_____

Previous counseling/therapy? Yes _____ No _____ If yes, when? _____

With whom? Please provide name and address _____

_____

C U R R E N T C O N C E R N S

On a scale of 1 - 10, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate each item.

0 = No Concern

5 = Moderate Concern

10 = Extreme Concern

_____ Anger | Temper

_____ Abused as a child

_____ Abused as a child

_____ Problems with parents

_____ Anger | Temper

_____ Education

_____ Use of drugs by self

_____ Use of drugs by family member

_____ Resentment

_____ Aggression

_____ Spiritual Concerns

_____ Bitterness

_____ Sexual Concerns

_____ Depression

_____ Stress | Anxiety

_____ Difficulty communicating

_____ Thought of suicide

_____ Appetite | Eating

_____ Trouble making decisions

_____ Education

_____ Unhappiness

_____ Family problems

_____ Use of alcohol by self

_____ Use of alcohol by family member

_____ Other addiction

_____ Marital concerns

_____ Grief | Loss

_____ Personality Conflicts

_____ Work

_____ Physical problems

_____ Trouble developing relationships

_____ Problems with children

_____ Other. Please specify

_____ _____

_____ _____

_____ _____

_____ _____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

Signature: _____ Date: _____

ADDITIONAL INFORMATION

Please use this page to write any additional information that would be helpful for the counselor to know about your current situation or significant events in your past.

Total Life Solutions

Family Background Form

Client _____ Date _____

YOUR MOTHER'S FAMILY

Your Mother's Father _____ DOB _____

If deceased, DOD _____

Your Mother's Mother _____ DOB _____

If deceased, DOD _____

Date of Your Mother's Parent's Marriage _____

Did they separate or divorce? If so, please indicate date _____

Were either of your mother's parents in other marriages? If so, please elaborate _____

_____

_____

_____

Your Mother's Name _____ DOB: _____

Your Mother's Siblings

_____ DOB _____ DOD _____

_____ DOB _____ DOD _____

_____ DOB _____ DOD _____

_____ DOB _____ DOD _____

Please list all of your mother's significant relationships, marriages and divorces – with dates

_____

_____

_____

Please elaborate on other significant situations, events or details that impacted your mother's life. Examples might include abuse, alcoholism in the family, trauma, or step-siblings, for example _____

_____

_____

_____

_____

_____

YOUR FATHER'S FAMILY

Your father's father _____ DOB _____

If deceased, DOD _____

Your father's mother _____ DOB _____

If deceased, DOD: _____

Date of your father's parent's marriage _____

Did they separate or divorce? If so, please indicate date _____

Were either of your father's parents in other marriages? If so, please elaborate _____

_____

_____

Your father's name _____ DOB _____

Your Father's Siblings

_____ DOB _____ DOD _____

_____ DOB _____ DOD _____

_____ DOB _____ DOD _____

_____ DOB _____ DOD _____

Please list all significant relationships, marriages and divorces – with dates _____

_____

_____

_____

Please elaborate on other significant situations, events or details that impacted your father's life. Examples might include abuse, alcoholism in the family, trauma, or step-siblings, for example _____

_____

_____

_____

_____

_____

SIGNIFICANT RELATIONSHIPS IN YOUR LIFE

Your Siblings. Please list all client sibling relationships – natural, half, step, etc

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other significant relationships that may have impacted your life. Examples might include teachers, coaches, neighbors, a special uncle or aunt, etc _____

_____

_____

_____

_____

How would you characterize your relationship with God as a teenager or young adult? _____

_____

_____

_____

_____

Is your relationship with God different today? Please explain _____

_____

_____

_____

_____

Additional thoughts or comments that might provide further insights into the dynamics of your family

_____

_____

_____

_____